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No. _____

Supreme Court, U.S.
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In The

# Supreme Court of the United States

October Term, 1993

JOSEPH PUDLO, M.D.,

*Petitioner,*

v.

E. ADAMSKI M.D., J. SCHNEIDER M.D., S. BORUSHEK, M.D., J. DADDINO M.D., GARY FAHRENBACH M.D., D. LARSON M.D., B. LEVY M.D., J. NABOLOTNY M.D., L. PANKAU M.D., V. VOHRA M.D. Individually, T.P. NASSOS M.D., E.W. BEUTEL M.D., Y. KIM M.D., J. COUGHLIN M.D., W. DAVIDSON M.D., F. GRABINER M.D., S. HADAWI, M.D., F. MARIANO M.D., D.L. MEYERS M.D., E.A. PETRUS M.D., L. PUPILLO, M.D., F. HEALEY M.D., A.R. MCCALL M.D., J. SCHNEIDER M.D., SISTER DONNA MARIA, CEO of the Hospital in their representative capacity and Resurrection Medical Center in Chicago, Illinois,

*Respondents.*

**Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit**

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

I. Whether the intra-corporate immunity doctrine excludes from antitrust liability every hospital and each physician who engages in anticompetitive activity by abuse of the medical staff peer review process to exclude a competitor physician from the marketplace?

If certiorari is granted on issue I, review of the following, related issue is also sought:

II. Whether a hospital is vicariously liable for failure to actively supervise combinations of physicians who through service on medical Staff Committees abuse the medical staff peer review process to unfairly restrain trade with their horizontal competitors?

## LIST OF THE PARTIES

All parties are named in the caption.

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## PETITION FOR WRIT OF CERTIORARI

### OPINIONS BELOW

The reported opinion of the United States District Court for the Northern District of Illinois granting Defendants' motion to dismiss, *Pudlo v. Adamski*, 789 F. Supp.

247 (N.D. Ill. 1992), is reproduced in App. 1. That decision was affirmed by the United States Court of Appeals for the Seventh Circuit in an unpublished opinion and judgment Docket No. 92-1854 entered on August 9, 1993. They are reproduced in App. 14 and App. 18. An unpublished opinion of the Federal Magistrate is reproduced in App. 19.

## STATEMENT OF JURISDICTION

The judgment of the Seventh Circuit Court of Appeals was entered on August 9, 1993. The statute that confers jurisdiction on this Court to review the judgment in question is 28 U.S.C. § 1254(1) and rule 10(1)(a) and (c) of this court.

## STATUTORY PROVISIONS INVOLVED

The Sherman Act, §1 states in relevant part as follows:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . . "

## STATEMENT OF THE CASE

Petitioner, Doctor Joseph Pudlo filed suit under §1 of the Sherman Act against various physicians on the medical staff of Resurrection Medical Center, Chicago, and the hospital itself. Dr. Pudlo alleged that the primary motive

for defendants conducting a "purported" medical staff peer review was to eliminate Dr. Pudlo as a high volume, low cost competitor of various defendant physicians under the pretext of concern with improving patient care.

Dr. Pudlo bought an established medical practice in August 1990 from a retiring doctor, who had admitted his patients to the defendant Hospital for more than thirty years. Dr. Pudlo applied for and was appointed a provisional Member of the Medical Staff with unlimited privileges in Internal Medicine. Dr. Pudlo significantly enhanced the volume of patients by working longer hours and charging lower fees than his competitors.

Dr. Pudlo practiced without any objections from the Medical Staff or the Hospital for ten months until defendant Dr. Adamski, plaintiff's geographically closest competitor outside the hospital, warned Dr. Pudlo that his practice was in jeopardy. Several days later Dr. Pudlo received a certified letter from Dr. Adamski acting as the Chairman of the Internal Medicine Committee of the hospital asking for a written response. A medical record of an 85 year old patient who suffered from an extremely rare and incurable condition had been routinely identified for examination by the hospital's risk management team. The case had been referred to the hospital's quality assurance committee and then came to the attention of Dr. Adamski, who Dr. Pudlo alleged seized this occasion to conspire with other internists in order to eliminate Dr. Pudlo from the staff and thus eliminate competition from the market outside the hospital as well. (Amended Complaint (hereinafter Am. C.)¶37).

Defendant Adamski, Pudlo's geographically closest competitor (Am. C.¶9) had also requested defendant Maria, the hospital's chief executive officer (CEO), to order the hospital's quality assurance staff to reaudit Dr. Pudlo's medical records from his initial appointment to the staff. (Am. C.¶19) Dr. Pudlo alleges that he was summoned to appear in front of the Internal Medicine department of the hospital (consisting solely of competitors) and required to answer charges posed for the first time in that meeting without being permitted to examine patient charts which in one case were nearly a year old. The Hospital did not make the patient records available to Dr. Pudlo so he could respond. No particulars were given to Dr. Pudlo as to which if any of his patients' medical records would be reviewed.

Dr. Adamski had secretly met with a few competitor internists to reexamine Dr. Pudlo's patient charts so that these additional charges could be made. Dr. Pudlo alleged that Dr. Adamski and other defendants had decided to remove Dr. Pudlo and that at a subsequent meeting on August 9, Dr. Adamski and other competitor physicians sought a pretext for their anticompetitive actions against Dr. Pudlo. This pretext chosen entailed using the hospital peer review mechanism to exclude one of their competitors. Dr. Pudlo alleged that these competitor physicians were not seriously interested in hearing explanations of the actual medical care delivered. The Internal Medicine Committee recommended that Dr. Pudlo be terminated from the staff. The Internal Medicine Committee consisted solely of defendant internists. The Medical Executive Committee, which included both Dr.

Adamski and three other competitors (4 out of 16 members), and the hospital Governing Board automatically accepted the recommendation.

Under the hospital bylaws a hearing committee was subsequently convened, consisting of physicians who were not competitors of Dr. Pudlo. Although Dr. Pudlo was given only vague notice of the allegations against him, Dr. Pudlo was entirely successful in his defense before the hearing committee. After Dr. Pudlo presented evidence on his behalf to the hearing committee, the committee unanimously found in favor of Dr. Pudlo and unanimously recommended that Dr. Pudlo's staff privileges be continued.

However, termination was recommended by the Medical Executive Committee even though they had not yet received the final detailed hearing committee report exonerating Dr. Pudlo. The recommendation of the Medical Executive Committee was adopted by the Governing Board of the Medical Center (a board of non-physician laypersons). (The Hospital took the position that the standards applied to physicians already on the staff of the hospital were not as high as the standards applied to someone seeking admission to the staff. This position Federal Magistrate Guzman found illogical and disturbing.)

Dr. Pudlo alleged that the Medical Staff Committee generally follow the recommendation of the members who practice in the same field of medicine as the physician under review – i.e. that in this case the Medical Executive Committee deferred to the decision of the competitor internists. The hospital governing board also was

alleged to have rubber stamped the recommendation of the Medical Executive Committee without having before it the full record or giving Dr. Pudlo an opportunity to identify and present the errors of the various committees below.

Dr. Pudlo also alleged that Dr. Adamski and the hospital CEO Maria ignored clear Department Criteria for Removal from Provisional status: which required consideration of: "Satisfactory performances of quality assessment reviews," as the foundation of the candidate's evaluation. [Adherence with such departmental criteria is required for hospital accreditation.]

## NATURE OF THE HOSPITAL MEDICAL STAFF RELATIONSHIP

A hospital and its self-governing medical staff are engaged in a cooperative venture to operate the hospital. The medical staff of a hospital consists of physicians accredited to the medical staff, who practice various specialties. As an internist, Dr. Pudlo competes with other internists in the Northwestern sections of Chicago medical care market, which market included, for Dr. Pudlo in particular, the market for Polish speaking patients. Chicago is the second largest city in the world in number of Polish speaking inhabitants. Internists such as Dr. Pudlo function as gatekeepers to hospitals – in many cases initially admitting patients to a hospital and providing referrals to other physicians in a hospital for specialized care such as that provided by surgeons or anesthesiologists.

A physician admitted to the staff of a hospital rarely derives direct payment from the hospital – but instead is paid by patients or their insurance companies for the physician's services. [Certain specialties are exceptions to this normal pattern – frequently these "hospital based physicians" such as pathologists are paid directly by the hospital.] On the other hand, hospitals are dependent upon the ability of gatekeeping physicians to admit paying patients. Hospitals and physicians are not direct competitors of each other – however, gatekeeping physicians compete with other similar physicians, including each medical staff member of any hospital to which a physician is admitted.

The economic interests of hospitals and staff physicians are clearly distinct from each other. Staff physicians who serve on hospital committees are thus potentially subject to a conflict of interest between their personal economic interest and the economic and other interests of a hospital.

Although the hospital board retains *de jure* power to disapprove particular actions the staff may recommend, it cannot discipline individual physicians directly or appoint non-physician officers to exercise direct authority over physicians in the practice of medicine.

The hospital medical staff organizational model with its crucial requirement of staff "selfgovernance" has long been mandated for hospital accreditation.[1] "If it is to tolerate professional quality assurance at all, antitrust law

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[1] Joint Commission on Accreditation of Health Care Organizations, Accreditation Manual 1992 Standard MS2.

must find ways of preventing the anticompetitive use of the power to label a practitioner as incompetent or neglectful of patient welfare." Havighurst, "Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships," 1984 Duke L.J. 1074, at 1151 *n7*. This Court has reviewed examples of peer review abuse in *Patrick v. Burget*, 486 U.S. 94, and *Summit Health Ltd. v. Pinhas*, ___ U.S. ___, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991).

## DECISIONS OF THE SEVENTH CIRCUIT AND THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS

The Seventh Circuit affirmed the decision of the United States District Court for the Northern District of Illinois (adopting its reasoning), and in doing so expanded the intra-corporate immunity doctrine beyond what any other United States Circuit Court of Appeals had done.

The Seventh Circuit rested it affirmance on a conclusion of law and fact that recommendations by Pudlo's direct competitors which were reviewed by the Executive Committee and the Hospital Governing Board could not involve a conspiracy because "the staff were acting in the same way that an officer of a corporation would act in relation to the corporation." In footnote 2, of its opinion the Seventh Circuit found that any possible resulting taint was removed by the fact that final authority was vested in the Hospital's Governing Board.

Such approach is against this Court's precedents on grant of immunities, against Congressional policy on

enforcement of antitrust laws in this area of commerce and most importantly an unjust and unfair expansion of a narrow doctrine not suited for this case. The holding of the United States Court of Appeals for the Seventh Circuit means that as a matter of law a hospital cannot conspire with its medical staff who are involved in internal peer review, nor can members of the medical staff involved in such internal peer review conspire with other members of the medical staff.

## REASONS FOR GRANTING REVIEW

### THERE IS A CLEAR CONFLICT AMONG THE JUDICIAL CIRCUITS, MANIFESTED BY THIS DECISION AS TO THE SCOPE OF POSSIBLE SHERMAN ACT § 1 CONSPIRACIES WITHIN THE HOSPITAL MEDICAL STAFF AND BETWEEN THE HOSPITAL MEDICAL STAFF AND THE HOSPITAL ITSELF.

First, there is a profound conflict among the circuits on this very important point of federal law as the opinion of the United States Court of Appeals for the Seventh Circuit recognized in footnote 2. The particular finding of law by the Seventh Circuit, to the extent that it goes further than decisions of other circuits, also appears to stand in square opposition to the position of this Court regarding unconditional grants of immunity from potential Sherman Act liability to hospitals in *Patrick v. Burget*, 486 U.S. 94 (1988).

Second, as a practical matter the abuse of hospital peer review process by competing physicians has led to increased antitrust litigation regarding one of the most significant sectors of the United States economy, (one

seventh of the entire GNP or $820 Billion in 1992 (U.S. Health Care Financing Review, Fall 1992, Table 8.)). (See, *Pinhas*,) Exclusion of this sector of the economy from the ordinary application of section one of the Sherman Act results in the promotion of anticompetitive actions so long as the mantra "quality of care" is chanted. The anticipated results would be higher prices, lower quality of care and fewer choices to consumers. Group boycotts and other pressures upon peers to conform to anticompetitive practices of physicians with the practical power to control the peer review process in hospitals may have far greater impact upon the health care economy than the exclusion of one competitor, Dr. Pudlo, from a single hospital. Indeed, the threat of such peer review procedures in terms of practical economics, if carried out, are equivalent to a death sentence for a healthy medical practice if not to the entire future of a physician who has been accused of "substandard care." Such threats are so serious that few physicians are likely to resist such peer pressures. Few such cases are likely to ever be litigated. Some circuits extended this theory with exemptions and other rejected it, creating an irreconcilable split among the circuits.

Third, the decision of the Seventh Circuit in this case decides important issues of law in apparent conflict with several decisions of this court. The Seventh Circuit decision in *Pudlo* went even beyond limits given by this Court in *Patrick v. Burget; de facto* rendering moot that unanimous decision. Moreover, the limited intra-corporate *Copperweld v. Independence Tube Corp.*, 467 U.S. 752 (1984) doctrine, predicated on the relationship between a corporation and its wholly owned subsidiary, was vastly

broadened. This Court carved a narrow exception from the Sherman Act in *Copperweld*, 467 U.S. 752, at 776-777. ("[W]e also note that size of any such gap is open to serious question.")

Fourth, Congress has recently reviewed limited antitrust immunities available to the health care industry and found that proper cases for antitrust application are those where the process is abused by competitors.

Fifth, various governmental antitrust enforcement agencies frequently encounter cases of anticompetitive abuse by physicians and their enforcement powers neither should be weakened nor as in *Pudlo* completely foreclosed.

## I. CONFLICT AMONG THE CIRCUITS

The Third, Eleventh, Ninth, Sixth, Second, and arguably the District of Columbia Circuits have found that competitors are not immune from Sherman Act § 1 if they abuse peer review process on the basis of the *Copperweld* doctrine. In *Weiss v. York Hospital*, 745 F.2d 786, 816 (3rd Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) the Third Circuit was the first to refuse to extend intra-corporate immunity to the physician's competitors. The Third Circuit revisited this point of law without making any substantive changes in *Nanavati v. Burdette Tomlin Memorial Hospital*, 857 F.2d 96 (3rd Cir. 1988), *cert. denied*, 849 U.S. 1078 (1989) Upon examination of evidence and finding that the Executive committee did not act at all on the facts alleged and absent allegation that it had any members who were plaintiff's competitors, the court held that the Executive Committee was not a combination as a matter

of law. Even *Nanavati's* (at 119 & 121) reasoning would distinguish it from *Pudlo,* who alleged The Executive Committees action involved four direct competitors. Therefore *Weiss and Nanavati* as matter of law make the actions of the Executive Committee a combination under Sherman § 1. Additionally, the Third Circuit in *Nanavati* refused to recognize individual members of the Staff acting as officers of the corporation, *de facto* recognizing the independent personal stakes exemption. *Id.* 118. The Court refused to reach the vicarious liability issue, because the plaintiff suffered no damage from the alleged conspiracy.

The Eleventh Circuit agreed with *Weiss, supra,* and held that members of a hospital's medical staff are fully capable of entering into a conspiracy among themselves in restraint of trade:

> We perceive no basis, however, for holding that the members of a medical staff are legally incapable of conspiring with one another. Each member practices medicine in his individual capacity; each is a separate economic entity potentially in competition with other physicians. *Bolt v. Halifax Hosp. Medical Center,* 891 F.2d 810, at 819 (11th Cir. 1990) *cert. denied,* 495 U.S. 924 (1990).

The Eleventh Circuit then logically concluded that the physicians serving under medical staff and its committees are independent legal entities, *Bolt v. Halifax Hosp. Medical Center,* 891 F.2d 810 (11th Cir. 1990), *cert. denied,* 495 U.S. 924 (1990) and "A hospital and the members of its medical staff, in contrast [to the unique considerations in

the ordinary corporate context] are legally separate entities, and consequently no similar danger exists that what is in fact unilateral activity will be bootstrapped into a conspiracy." 891 F.2d at 819.

The Eleventh Circuit considered yet another privileges dispute, *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438 (11th Cir. 1991) which arose outside of quasi-judicial peer review process, predicated on the Hospital's Board refusal to grant particular privileges to a neurologist, Todorov, in the Department of Radiology where the service was contracted to a group of radiologists. Todorov failed to demonstrate a genuine issue of material fact alleging conspiracy between the hospital and competing physician. The court reaffirmed its holding in *Bolt supra, Todorov* at 1455, and explained that *Copperweld* doctrine turns on the facts relative to physicians independence. *Todorov fn29* at 1455.

In *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988), the Ninth Circuit recognized that "the M.D. anesthesiologists may have been the agents of St. Peter's for some purposes", however it declined to apply intra-corporate immunity doctrine because:

> "their interests were not as wed as the ties between a corporation and its officers or employees. St. Peter's did not pay the anesthesiologists a salary . . . Those interests were sufficiently independent so that the collaborative conduct between the anesthesiologists and St. Peter's coalesced economic power previously directed at disparate goals." *Oltz*, at 1450.

To distinguish *Oltz* on the grounds that the conspirators acted outside the peer review process, would constitute a

dangerous invitation to the federal judiciary to extend additional immunities for the most frequently abused, yet most powerful tool available to the health care industry so as to restrain competition. Production of this result by judicial adoption was precisely what this Court warned against in *Patrick* at 1665: *"This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such, is properly directed to the legislative branch. The Copperweld doctrine's application turns on the complete unity of interests between a corporation and the members of it's unincorporated subdivision and not on the type of activity that a subdivision is performing. Copperweld* 467 U.S. at 771. See also, *Spence v. Southeastern Alaska Pilot's Assn.*, 789 F. Supp. 1014, at 1022 (D. Alaska 1992).

In *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605 (6th Cir. 1991), *cert. denied* 112 S.Ct. 406 (1991) the Sixth Circuit applied the intra-corporate immunity to the hospital and its medical staff, but nevertheless refused to recognize the competitors as agents, *de facto* applying a personal stakes exemption.

The Second Circuit recognized the reality of the separate economic interests of independent practitioners with its decision in *Capital Imaging Associates P.C. v. Mohawk Valley Medical Associates, Inc.*, 996 F.2d 537, 544 (2nd Cir. 1993).

The D.C. Circuit does not have a split within as initially might appear. In *Okusami v. Psychiatric Institute of Washington*, 959 F.2d 1062, at 1064 (D.C.Cir. 1992) the court stated: "Interesting as these issues are, we need not resolve any of them today," because of the absence of

allegations of any competing interest between Dr. Hoffman, the medical director of the defendant, and the Institute. The court held on the pleadings in *Okusami* that the intra-corporate immunity doctrine applied. However, in *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210 (D.C.Cir. 1986), cert. den. 479 U.S. 1033 (1987) a panel (including Judge Bork and then Judge now Justice Ginsburg) held *inter alia*: " . . . [T]he Atlas Board of Directors consisted of actual or potential competitors of Atlas and that is also sufficient to take this case out of the *Copperweld* rule." While *Rothery* dealt with the common carriage of goods, not the hospital marketplace, the court clearly indicated that the specific facts of the situation controlled, and cited as authority this court's decision in *National Collegiate Athletic Association v. Board of Regents*, 468 U.S. 85 (1984). The horizontal restraint between competitor university members of the NCAA took the case out of the *Copperweld* doctrine. (792 F.2d 214-15).

In its *Pudlo* decision the Seventh Circuit joined the Fourth Circuit in *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), cert. denied, 112 S.Ct. 873, 117 L.Ed.2d 137 (1992) holding that a hospital is incapable of conspiring with its medical staff during the peer-review process. However, in *Oksanen* the Fourth Circuit was presented with unusual and unique facts, since the disciplinary action was initiated by the hospital's board and not the physician's competitors after complaints came from many sources. Moreover, fair procedures were observed and any competitor's impact on those procedures was minimal. 945 F.2d 705-707. The reality is that the Fourth Circuit engaged in a practical construction and application of HCQIA which, as the court noted, did not

apply. 945 F.2d at 704. n.2.[2] Moreover, the Fourth Circuit held: "While the members of a medical staff may have the capacity to conspire among themselves, such a conspiracy did not occur in this case." 945 F.2d at 699. The Seventh Circuit's decision goes further than the Fourth Circuit's decision.

Had the Fourth Circuit in *Oksanen* fully analyzed and understood the clear warning from this Court in *Patrick v. Burget*, (a case the Fourth Circuit fails to even cite), the Fourth Circuit would have granted only limited immunity.[3] If the Health Care Quality Improvement Act of 1986 (42 U.S.C. sec. 11101 et seq.) "provides in sufficient immunity to protect the peer-review process fully, [physicians] . . . must take the matter up with Congress." 486 U.S. at 105 n.8. Dr. Pudlo would suggest that the Fourth Circuit in *Oksanen* was moved by the appropriateness of the peer review procedures actually employed (which stand in stark contrast to those Dr. Pudlo alleges in his

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[2] "The Congress further noted that '[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review' 42 U.S.C. § 11101(4) & (5). This legislation, however is not controlling in this litigation which concerns events accruing before the Act's effective date." 945 F.2d at 704, n.2.

[3] "Congress in fact insulated certain medical peer-review activities from antitrust liability in the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11112(a). . . . In enacting this measure, Congress clearly noted and responded to the concern that the possibility of antitrust liability will discourage effective peer review. If physicians believe that the Act provides insufficient immunity to protect the peer-review process fully, they *must* [emph. added] take that matter up with Congress." *Patrick v. Burget*, 486 U.S. at 105, n.8.

case) and was unaware of the full measure of public policies involved but acted in a misguided desire to further shield peer review process. The Fourth Circuit then embarked on an ill-advised journey of blanket immunity. The Seventh Circuit in Pudlo completed the journey by reaching a conclusion of law that suffocates competition among physicians. Indeed, the Seventh Circuit's decision would provide a *How to Do it Manual* for anti-trust conspirators.

## II. THIS COURT'S DECISION OF PATRICK V. BURGET HAS BEEN RENDERED MOOT BY THE SEVENTH CIRCUIT'S DECISION REGARDING DR. PUDLO; SUCH AN IMPORTANT RULING OF LAW DESERVES THE ATTENTION OF THIS COURT

The District Court in *Pudlo* failed to adequately appreciate that the Medical Staff is not a "wholly owned entity of the Hospital" and established a policy of *per se* exemption for the health care industry, a policy adopted by the Seventh Circuit. However, this Court declined to adopt exactly such a policy in *Patrick v. Burget*, under the rubric of state action and referred the matter to Congress should additional corrective action be needed. The Seventh Circuit's decision in *Pudlo* does not even require the hospital to actively supervise physician controlled peer review processes (for example by making certain that competitor physicians cannot exercise improper influence on the process) but permits the hospital to rubber stamp kangaroo court processes that do not (and need not) accord with the elementary requirements of HCQIA (including such matters as the notice of specific charges).

This Court repudiated such wholesale exemption from the antitrust laws in *Patrick v. Burget*. The question of whether the Seventh Circuit is correct in adopting such a radical policy break is such an important one that it deserves this court's attention. At a bare minimum, an active supervision policy should be applied to ensure that peer review does not conceal cloakroom antitrust conspiracies. [Indeed, as both government and the private sector impose more economic pressure upon physicians and hospitals to control health care costs, an ironic response by many physicians seeking to maintain their existing income levels may be to increase unfair anti-competitive efforts using peer review as a weapon.]

## III. CONGRESS HAS REJECTED EXTENSION OF IMMUNITIES

In *Patrick* this Court referred any request for additional immunities to Congress, which indeed acted the following year by enactment of the Omnibus Budget Reconciliation Act of 1989 which required the General Accounting Office to study and report on physician antitrust issues. The report issued in 1991, *Physician Antitrust Issues-GAO Views;* ¶ 50,062 Trade Regulation Reports 48,714; stated:

> "Hospital peer review is subject to Anti-Trust scrutiny but is likely to violate the law only when the process is abused. . . . Thus, medical staff of a hospital may engage in peer review without undue antitrust exposure by establishing procedures to ensure that medical peer review activities are conducted in good faith with safeguards for the rights of those subject to

> review and competitors of the doctors under review do not wield the ultimate power. . . . " 48,717.
>
> In conclusion the GAO Report states: "However, the antitrust laws should not unduly interfere with responsible actions by physicians or payers to achieve either end. *Moreover, the risk of anti-competitive effects should be considered before deciding that a further legislative exemption from antitrust scrutiny is warranted. Hospital-based peer review is already exempt to a large extent.*" [emph. added] Id. 48,722

Congress has not acted to further extend immunities since the receipt of the report.

Congress has ratified by its actions the decision of this court in *Patrick* to permit federal antitrust oversight to continue. Both Congress's actions (by enacting HCQIA) as well as by commission of a study and subsequent inaction ratify the view that the Sherman Act remains needed to ensure that hospital staff's delegated powers are not being abused at the expense of competitors and consumers. Congress has explicitly recognized that the peer review process remains potentially tainted by the medical staff's inherent conflict of economic interests.

For example, in the case at bar, the decision of the Seventh Circuit ignored well-pleaded allegations that the Executive Committee of the hospital, numerical composition notwithstanding, had four members who were Plaintiff's direct competitors. (AC¶¶ 23&33) The complaint alleged that the Executive Committee defers its decisions to the decisions of the specialists in the field of

review.(AC¶ 23) Therefore, Plaintiff sufficiently alleged that the four competitors on the Executive Committee infected the decision making process. This clear set of allegations address directly the fear that Congress recognized as legitimate in its enactment of HCQIA in 1986 – a peer review process can be abused. Dr. Pudlo alleged that the dynamics of decision making on the Medical Executive Committee was such that his competitors argued and voted for the object of their plot with no opportunity to Dr. Pudlo to present his case. *This vote took place before the Medical Executive Committee received the complete hearing committee report which vindicated Dr. Pudlo entirely.* To expect that the Hospital Governing Board, a body of non-physicians, will exercise independent control in such a situation blinks reality.

The United States Court of Appeals for the Seventh Circuit should not be permitted to off-handedly dismiss well-pleaded facts and interpret the circumstances of the case just to buttress a novel theory of law. Such a practice is not supported by the authorities of this Court. *Conley v. Gibson,* 355 U.S. 41, 45-48 (1957).

On the motion to dismiss the court must construe all facts in light most favorable to the Plaintiff. *Poller v. Columbia Broadcasting System,* 368 U.S. 464, 473 (1962). The Seventh Circuit both ignored the pleading and arguments presented to it, and drew conclusions supported neither by law nor by common sense. Any decision to close federal courthouses to such action should only be made by Congress.

## IV. ANTITRUST AGENCIES HAVE FOUND ABUSES BY PHYSICIANS SEEKING TO CONTROL HOSPITAL DECISIONS; ANTITRUST ENFORCEMENT IS STRONGLY FAVORED BOTH BY FEDERAL AND STATE AGENCIES AND BY PRIVATE ANTI-TRUST LITIGANTS

Recent actions by the Federal Trade Commission which resulted in settlements demonstrate that the possibility of hospital "capture" by medical staff physicians are not illusory but unfortunately all too real in the health care marketplace. In both cases threatened boycotts by the Medical Staff of two Fort Lauderdale, Florida, hospitals were enjoined, boycotts that had been aimed at coercing Hospital Boards not to accept the lower priced competitors from the Cleveland Clinic. *Medical Staff of Holy Cross Hospital, C-3345, and Medical Staff of Broward General Medical Center C-3344, 56 Fed. Reg. p.49,184, No. 188(Sept. 27, 1991), Diran Seropian M.D. Dkt. No 9248, 57 Fed. Reg. 44,748, No. 189 (Sept. 29, 1992) (consent orders)* Such cases demonstrate the hospital's inability (unaided by antitrust law) to control anti-competitive Medical Staff behavior, and demonstrate the utility of federal antitrust supervision. [The Senate Finance Committee heard testimony from Hillary Clinton on September 30, 1993, chairwoman of the Presidential Task Force on Health Care Reform: "Health Care System in this country stifles competition".]

On May 7, 1993, the Senate Committee on Finance, Subcommittee on Medicare and Long-term Care heard the testimony by two enforcers of antitrust laws who strongly supported continued antitrust oversight over the health care delivery system. They stated: "[A]ny decision

to abandon competitive principles should be the decision of the State governments." Trade Regulation Reporter ¶ 50,104 at 48,900. Ms. Ellen Cooper, Chief of the Antitrust Division of the Maryland Attorney General's Office, also a Chairperson of the Health Care Working Group of the National Association of Attorney's General.

"[A]ntitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system. . . . " Mr. James C. Egan, Director for Litigation for the FTC's Bureau of Competition, *Id.* ¶ 50,105 at 48,904.

Cartels of physicians with the power to admit or not to admit the patients to a given hospital make the Hospital Board as a matter of "practical economics" without power to control them. See, Kissam et al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom,* 70 Cal.L.Rev. 595, 605-613 (1982).

Professor Areeda has also recognized the possibility that Hospitals may be coerced to adopt decisions of the Medical staff members. "The illegal conspiracy among the doctors . . . did not lie in their recommendations but apparently in their collective coercion of the hospital." Areeda, *Antitrust Law,* at 301 ¶ 1471h. (discussing *Weiss*)

## V. THIS COURT HAS CONSISTENTLY HELD THAT SHERMAN ACT § 1 MUST BE ENFORCED EVEN WHEN A SINGLE COMPETITOR IS INVOLVED

The very existence of the combination of physician competitors, in a joint venture with a hospital empowered to decide the fate of other physicians, is an

appropriate issue for Federal antitrust scrutiny. This court has frequently considered the effects of action taken against a single individual plaintiff. Consumers may have much more at stake in cases of this kind than their interest in the fate of many other competitors whose presence or absence from the market may be more obvious.

Dr. Pudlo alleges he was unjustly and unfairly victimized by his competitors and competition was thereby injured. His case is just as worthy of this Court's attention as was a retailer's from San Francisco, *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), a surgeon's from Astoria, Oregon, *Patrick supra* and an ophthalmologist's from Los Angeles, *Summit Health Ltd. v. Pinhas*, ___ U.S. ___, 111 S.Ct. 1842 (1991). This court has frequently protected competition through application of § 1 of the Sherman Act. No competitor is too small or too unimportant to be reached by § 1, although examination of the economic facts and the substance of the controversy underpin antitrust jurisprudence.

In *Klor's Inc. supra*, the Plaintiff's insignificance and failure to allege any general "public harm" were no bar to finding that a substantive violation had been sufficiently alleged. The Court stated that a group boycott "is not to be tolerated merely because the victim is just one merchant, whose business is so small that his destruction makes little difference to the economy" *Id.* at 213. The point is well taken, not because antitrust law is designed to protect small business, but because true group boycotts of the kind alleged in *Klor's* are naked restraints that deprive "the marketplace of the independent centers of decision making that competition assumes and

demands." *Copperweld Corp. v. Independent Tube Corp.*, 467 U.S. 752, 769 (1984). The potential harm to competition that exists whenever horizontal competitors repeatedly make decisions affecting the fate of other competitors, should be considered in any case brought by an individual victim. *Pinhas supra.* Special opportunities for abuse arise when combinations of physicians exercise *de facto* control over professional practice. This Court pointed out that a self regulated industry must adhere to fair procedure to ferret out anticompetitive practices or else be subjected to very strict antitrust scrutiny. *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963) A medical staff, left free by a hospital to pursue its members' collective interest, should not have its actions immunized from antitrust scrutiny just because they affect only one competitor at a time. Havighurst, "Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships," 1984 Duke L.J. 1074, at 1142-44.

## VI. THE QUESTION OF WHETHER THE HOSPITAL MAY BE VICARIOUSLY LIABLE FOR AN ABERRANT PEER REVIEW PROCESS, WHEN THE HOSPITAL HAS BEEN PROPERLY PUT ON NOTICE, IS AN IMPORTANT QUESTION OF LAW

The decision of the Seventh Circuit court implicitly holding that vicarious liability is not applicable also establishes an important rule of law deserving of this court's attention. The District Court in *Pudlo* reasoned that the conspiracy of the individual competitors is not actionable since the ultimate authority for this decision is retained by the Hospital Board. That part of the decision

was not supported by the Sixth Circuit's decision of *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605, 614-15, as modified, 927 F.2d 904 (6th Cir. 1990), *cert. denied*, 112 S.Ct. 406 (1991).

In *American Society of Mechanical Engineers Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982) this Court stated that the principal is vicariously liable for the acts of its agents. Vicarious liability turns on the degree of control and not mere authority for the decision. "The anticompetitive practices of ASME's agents are repugnant to the antitrust laws . . . and ASME should be encouraged to eliminate the anticompetitive practices of all its agents acting with apparent authority, especially those who use their positions in ASME solely for their own benefit." *Id.* at 574. The importance of *actual* exercise of control in eliminating the antitrust violation has been eloquently stated by Professor Areeda:

> "[T]he disloyalty may be rather modest from the employer's viewpoint and still cause a significant restraint on competition. The employer's own interest may be affected *so little by the disloyalty that he has little incentive to bear the monitoring costs of preventing it.* Or he may be an inefficient manager. Or the disloyalty may be successfully hidden from him. An antitrust remedy may bring the facts to light, encourage supervision, and compensate the plaintiff for injuries caused by the employer's anticompetitive behavior." Areeda, Antitrust Law, Vol. VII, (1986) ¶ 1471d2, at 292.

> "Causation is clearly absent where the firm's decision is ultimately made *de novo* by a superior official. . . . Formal position is not determinative. A particular member may have a disproportionate effect on the dynamics of a

committee. Superior officials may automatically adopt lower level recommendations or may be misled by the way data or arguments are presented." *Id.* ¶ 1471G. AT 299.

Compare, *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989) (physician controlled health care plans could have an impermissible effect on competition). Accord, *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982) (Health care plans may reimburse members and nonmembers differently, both in price and manner, so long as physicians do not control the health care plan.) See also, *Pennsylvania Dental Ass'n v. Medical Serv. Ass'n of Pa.*, 745 F.2d 248 (3rd Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985) (effective control of plan by dentists not shown); *Royal Drug Co. v. Group Life and Health Ins.*, 737 F.2d 1433, 1436-37 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985) (same); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 480-81 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (challenged plans were mere "agents of their member physicains" and were in substance combinations of physicians).

Such cases illustrate that under the Sherman Act § 1, courts will carefully examine arrangements in which groups of physicians have the theoretical or actual ability to control the terms on which they compete. In cases where physicians are *de facto* decision makers of what otherwise seems to be an independent entity, such precedents authorize piercing the formal structure to find the requisite prohibited conduct when physicians are in fact "calling the shots." There is no reason to treat hospitals any differently if they permit their decisions regarding

medical staff privileges to be effectively controlled by an anticompetitive cartel of interested physicians.

## CONCLUSION

Claims by hospitals and physicians that the threat of antitrust suits deters responsible peer review and quality assurance in hospitals need not be taken seriously, because a hospital and its medical staff can escape close antitrust scrutiny of their peer review activities by not permitting the competitors to sit in judgement and following a fair procedure and so take advantage of limited immunity granted by Congress.

> "Over the past several years medical costs have increased at a rate far in excess of inflation. . . . In situations where health care providers violate antitrust laws, these increases are needlessly exacerbated. It is in everyone's interest to have medical costs include only those costs appropriate under the law." *Wei v. Bodner*, 127 F.R.D. 91 at 95 (D.N.J. 1989).

The facts of this case lend themselves to this Court's ability to resolve the conflict among the Circuits, to affirm the reasoning of *Patrick* and reject the new immunity so as to finally and firmly direct the industry to avail themselves to the limited immunities as set out by Congress in HCQIA.[4]

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[4] Bloomstein & Sloan, *Antitrust and Hospital Peer Review*, 51 Law and Contemporary Problems, 7, at 92: HCQIA calls for peer review by persons, "not in direct competition with the physician involved. That type of requirement would go far in reducing the

At the same time the lower courts should be directed to summarily dismiss antitrust complaints where the immunities have been complied with, but on the other hand federal courts should not be closed to the victims of antitrust abuses.

If the hospital and its medical staff are legally incapable of conspiring among themselves, then the physicians' competitors who abuse peer review process should be subjected to clear risk of antitrust liability. The hospitals, nevertheless, should be found vicariously liable for the anti-competitive conduct of their authorized agents.

For the reasons stated, the petitioner respectfully prays this Court to grant a writ of Certiorari to review the decision of the United States Court of Appeals for the Seventh Circuit and resolve the important questions presented regarding one of the most significant sectors of the United States economy.

Respectfully submitted,

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control of staff physicians on the hospital staff decisions. . . . [Y]et it would preserve the quality assurance function performed by peer (but not competitive) physicians." *See also,* Havighurst, *Professional Peer Review and the Antitrust Laws,* 36 Case Western L. Rev. 1117 (1986).

**Joseph PUDLO, M.D., Plaintiff,**

**v.**

**E. ADAMSKI, M.D., Jr., J. Schneider, M.D., S. Borushek, M.D., J. Daddino, M.D., Gary Fahrenbach, M.D., D. Larson, M.D., B. Levy, M.D., J. Nabolotny, M.D., L. Pankau, M.D., V. Vohra, M.D., Individually, T.P. Nassos, M.D., E.W. Beutel, M.D., Y. Kim, M.D., J. Coughlin, M.D., W. Davidson, M.D., F. Grabiner, M.D., S. Hadawi, M.D., F. Mariano, M.D., D.L. Meyers, M.D., E.A. Petrus, M.D., L. Pupillo, M.D., F. Healey, M.D., A.R. McCall, M.D., J. Schneider, M.D., Sister Donna Maria, Chief Executive Officer of the Hospital, in their representative capacity and Resurrection Medical Center, in Chicago, Illinois, Defendants.**

**No. 91 C 7474.**

United States District Court,
N.D. Illinois, E.D.

March 16, 1992.

MEMORANDUM OPINION
AND ORDER

ASPEN, District Judge:

This antitrust action arises out of plaintiff's termination from his medical staff membership at defendant Resurrection Medical Center (hereinafter "Hospital"). Plaintiff Joseph Pudlo, M.D., brings this five-count amended complaint against the Hospital, ten rival internists, sixteen members of the Hospital's Executive Committee and Sister Donna Marie, Chief Executive Officer and member of the Governing Board of the Hospital, alleging violations of §§ 1 & 2 of the Sherman Act (Counts I-III), tortious interference with a business relationship (Count IV) and breach of contract (Count V). Presently

before the court is defendants' motion to dismiss Pudlo's amended-complaint pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. For the reasons stated below, we grant the motion.

## I. Background[1]

Pudlo, an internist, purchased a primary care practice from Dr. Leo Stolarski on August 1, 1990. Stolarski had used the defendant Hospital as the exclusive facility to admit his patients for more than thirty years. Pudlo obtained a provisional medical staff membership with privileges in the Department of Internal Medicine at the Hospital. His practice with the Hospital began on August 1, 1990 and continued until November 18, 1991, during which time he treated more than 300 patients.

The difficulties between Pudlo and the defendants began in mid-June, 1991. At this time, defendant Dr. E. Adamski, Chairman of the Department of Internal Medicine and member of the Executive Committee of the Hospital, advised Pudlo that the Internal Medicine Committee was in the process of reviewing the quality of care given to one of his patients. Adamski further stated that unless Pudlo explain certain deficiencies in this case, Pudlo's practice "may be in jeopardy." Several days later,

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[1] Of course, as with all motions to dismiss, we take the "well-pleaded allegations of the complaint as true and view them, as well as reasonable inferences therefrom, in the light most favorable to the plaintiff." *Balabanos v. North Am. Inv. Group, Ltd.*, 708 F.Supp. 1488, 1491 n. 1 (N.D.Ill.1988) (citing *Ellsworth v. City of Racine*, 774 F.2d 182, 184 (7th Cir.1985), *cert. denied*, 475 U.S. 1047, 106 S.Ct. 1265, 89 L.Ed.2d 574 (1986)).

Pudlo received a letter from Adamski, dated June 17, 1991, detailing the issues raised by the Internal Medicine Committee and demanding a written response prior to the Committee's July meeting.

In an effort to comply with the June 17, 1991 letter, Pudlo requested the patient's records from the Medical Records Department at the Hospital. However, the Medical Records Department refused Pudlo's request, informing him that the case records were being reviewed by the Quality Assurance Committee. On July 17, 1991, Pudlo received a registered letter from Adamski indicating that the Internal Medicine Committee had not obtained a response to the June 17, 1991 letter and that a failure to respond may jeopardize his staff appointment. That same date, Pudlo received yet another letter from Adamski, stating that the Committee found several deficiencies in the medical record of an additional patient.

Pudlo responded with a letter addressed to Adamski, dated August 1, 1991, in which he described his understanding of the history of the patients' cases. This letter was sent prior to the next regularly scheduled meeting of the Department of Internal Medicine – August 9, 1991. Rather than waiting until the August meeting to address the issue, Adamski met with several unidentified internists on July 31, 1991. Pudlo contends that during this meeting, the physicians "discussed and agreed upon ways to exclude Plaintiff from the Hospital."

By means of a certified letter dated July 31, 1991, Adamski asked Pudlo to attend the August 9, 1991 meeting of the Internal Medicine Committee. During the course of that meeting, Pudlo learned that four additional

cases of his were under review. Without prior notice of the identity of medical records to be reviewed, Pudlo was unprepared to answer questions respecting these cases. Following the meeting, the members of the Committee recommended to the Executive Committee termination of Pudlo's medical staff appointment.

The Executive Committee is comprised of sixteen physicians at the Hospital, four of whom practice in the Department of Internal Medicine. According to Pudlo, other members of the Executive Committee generally follow the recommendations of the members who practice in the same area as the physician under review. Here, the Executive Committee recommended to the Hospital's Governing Board that Pudlo not be removed from his provision status, resulting in his automatic termination from his staff appointment. On September 13, 1991, via certified letter, Sister Donna Marie, Chief Executive Officer and member of the Hospital's Governing Board, advised Pudlo that his medical staff appointment had been terminated by action of the Governing Board.

Pursuant to the Medical Staff Bylaws, Pudlo requested a hearing before the Appeals Committee, and one was scheduled for October 9, 1991. Adamski, the first witness to testify, addressed Pudlo's deviations of care in those cases reviewed by the Internal Medicine Committee. Contending that Adamski's testimony was vague, Pudlo's attorney moved for a directed verdict, but was denied. Additionally, Pudlo's attorney requested the opportunity to cross-examine Adamski. Faced with Adamski's threats to leave the hearing, the Committee denied the request. After the conclusion of Adamski's testimony, Pudlo was questioned by various members of

the Committee. On his own behalf, Pudlo presented the testimony of Dr. Elliot Kroger, an expert witness. The Medical Staff Bylaws compel the Appeals Committee to send Pudlo, via certified mail, a copy of its findings within twenty days of the hearing. Pudlo did not receive such a report.

The results of the appeal were reviewed by the Executive Committee at its November 6, 1991 meeting. Finding the Appeals Committee's report incomplete, the Executive Committee requested a more detailed report from Dr. Gorny, the Chairman of the Appeals Committee. Nonetheless, at that very meeting, the Executive Committee recommended termination of Pudlo's staff appointment. Pudlo sought a stay of the Executive Committee's decision, pending the more detailed report to be filed by the Appeals Committee. Both Appeals Committee reports unanimously recommended that Pudlo should be removed from provisional status (*i.e.*, continuing his medical staff membership). Despite the favorable reports from the Appeals Committee and Pudlo's attempts to petition the individual members of the Governing Board, the Board terminated his medical staff appointment.

II. Section 1 Claims (Counts I & II)

In order to state a claim under Section 1 of the Sherman Act, 15 U.S.C. § 1, a plaintiff must plead the existence of an agreement in the form of a contract, combination or conspiracy that imposes an unreasonable restraint on trade. *Business Elec. Corp. v. Sharp Elec. Corp.*, 485 U.S. 717, 723, 108 S.Ct. 1515, 1519, 99 L.Ed.2d 808 (1988); *Havoco of Am., Ltd. v. Shell Oil Co.*, 626 F.2d 549,

554-55 (7th Cir. 1980).[2] Thus, in the context of a medical staff privilege case, a plaintiff initially must allege that the revocation of his privileges was a result of an agreement between two or more separate entities. A liberal reading of Pudlo's amended complaint reveals two theories of conspiracy culminating in the termination of his medical staff appointment: (1) that the Hospital conspired with the members of its medical staff; and (2) that individual members of the Hospital's medical staff conspired among themselves.

Relying on the doctrine of intracorporate immunity, expounded in *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 104 S.Ct. 2731, 81 L.Ed.2d 628 (1984), defendants argue that neither of the alleged conspiracies detailed in Pudlo's amended complaint is cognizable under Section 1 of the Sherman Act. *Copperweld* is widely cited for the following propositions: (1) an agreement between a parent corporation and its wholly-owned subsidiary is not a concerted action for purposes of Section 1;

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[2] As a jurisdictional prerequisite to any action brought under § 1 of the Sherman Act, a plaintiff must allege that the potential injury will affect interstate commerce. *See Summit Health, Ltd. v. Pinhas*, ___ U.S. ___, 111 S.Ct. 1842, 1847, 114 L.Ed.2d 366 (1991). In the instant case, Pudlo notes that the Hospital purchases medical supplies and equipment and receives insurance revenues from out-of-state sources. Further, Pudlo alleges that, given its close proximity to O'Hare International Airport, the Hospital served non-Illinois patients. Finally, Pudlo argues that the termination has diminished his ability to obtain a staff membership at any hospital in the United States. Given the Supreme Court's recent holding in *Pinhas*, we believe the above allegations meet the jurisdictional requirement for an antitrust action.

(2) an agreement between officers or employees of the same firm does not ordinarily constitute a Section 1 conspiracy; and (3) a corporation is legally incapable of conspiring with its agents or employees. *See id.* at 769, 104 S.Ct. at 2740-41. The driving force behind these principles is that "officers of a single firm are not separate economic actors pursuing separate economic interests." *Id.* Indeed, "[c]oordination within a firm is as likely to result from an effort to compete as from an effort to stifle competition. In the marketplace, such coordination may be necessary if a business enterprise is to compete effectively." *Id.*

The question of whether a hospital is legally capable of conspiring with its medical staff appears to be an issue of first impression within this circuit. Several other circuits, however, have considered the issue, rendering polarized opinions. *Compare Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 702-05 (4th Cir.1991) (hospital incapable of conspiring with its medical staff during the peer-review process), *cert. denied*, ___ U.S. ___, 112 S.Ct. 973, 117 L.Ed.2d 137 (1992) *and Nurse Midwifery Assoc. v. Hibbett*, 918 F.2d 605, 614 (6th Cir.1990) ("intracorporate conspiracy doctrine prevents a finding of conspiracy between a hospital and its medical staff"), *cert. denied*, ___ U.S. ___, 112 S.Ct. 406, 116 L.Ed.2d 355 (1991) *and Nanavati v. Burdette Tomlin Memorial Hosp.*, 857 F.2d 96, 118 (3d Cir.1988) ("a hospital could *not* conspire with its medical staff, as an entity") (emphasis in original), *cert. denied*, 489 U.S. 1078, 109 S.Ct. 1528, 103 L.Ed.2d 834 (1989) *and Weiss v. York Hosp.*, 745 F.2d 786, 814 (3d Cir.1984) ("hospital cannot legally conspire with its medical staff"), *cert. denied*, 470 U.S. 1060, 105 S.Ct. 1777, 84 L.Ed.2d 836 (1985) *with Oltz v. St. Peter's Community*

*Hosp.*, 861 F.2d 1440, 1450 (9th Cir.1988) (rejecting the analogy to the intracorporate immunity doctrine) *and Bolt v. Halifax Hosp. Medical Center*, 851 F.2d 1273, 1280 (11th Cir. 1988) (same), *cert. denied*, 495 U.S. 924, 110 S.Ct.1960, 109 L.Ed.2d 322 (1990).

Whether the medical staff's relationship to the Hospital is sufficiently analogous to an officer's relationship to the corporation involves an inquiry of "substance, rather than form." *Oksanen, 945 F.2d at 703.* Thus, a mere finding that the Hospital's medical staff *sometimes* pursues economic interests apart from the Hospital is inadequate to conclude that the Hospital is *always* capable of conspiring with its medical staff. *See id.* (criticizing the *Bolt* court for ignoring the functional approach mandated by *Copperweld*). Rather, we must examine the substance, rather than form, of the Hospital's relationship with its medical staff within the specific context of the peer-review process.

Most significant to the present inquiry is the fact that the Hospital's Governing Board delegated peer-review decisionmaking in the first instance to the medical staff. In accordance with the Hospital's bylaws, Dr. Adamski, Chairman of the Department of Internal Medicine, solicited information from other internists affiliated with the Hospital in order to make his mandatory recommendation to the Executive Committee concerning whether to remove Pudlo from provisional status. *See* Bylaws art. III, §§ 4-5. This participation cannot be characterized as conduct adverse to the Hospital. To the contrary, the medical staff functioned as an integral component of the Hospital's management structure, utilizing its expertise in medical care to make an initial determination of whether

Pudlo had achieved a certain level of professional competence. Further, to the extent that individual members of the medical staff may opt to pursue interests that are antithetic to those of the Hospital, the Governing Board is not bound by the determination of the medical staff. Indeed, the bylaws, in accord with state law, specifically vest the Governing Board with the ultimate authority over peer-review decisions: "The Governing Body is responsible for the final decision, based on medical staff recommendations, regarding an individual's reappointment and/or renewal or revision of individual clinical privileges." Bylaws art. III, § 4. Given the nature of this delegated authority – authority present in *Oksanen* and absent in *Oltz* – we are compelled to conclude that, with regard to Pudlo's termination, the medical staff acted as an officer of a corporation would in relation to the corporation. Accordingly, we recognize the applicability of the intracorporate immunity doctrine to peer-review proceedings (*i.e.*, the Hospital is legally incapable of conspiring with its medical staff during the peer-review process).

The question of whether members of the medical staff are capable of conspiring among themselves during the peer-review process is a different matter. We recognize that the members of the Hospital's medical staff often are driven by competing economic interests. Consequently, "when these actors join together to take action among themselves, they are unlike a single entity and therefore they have the capacity to conspire as a matter of law." *Oksanen*, 945 F.2d at 706 (citing *Nurse Midwifery*, 918 F.2d at 614); *see also Weiss*, 745 F.2d at 814. Nonetheless, this theory of Section 1 conspiracy is not actionable. As a general prerequisite to the maintenance of a private cause

of action under the antitrust laws, a plaintiff must allege "antitrust injury," which is to say "injury of the type that the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful." *Atlantic Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 334, 110 S.Ct. 1884, 1889, 109 L.Ed.2d 333 (1990); *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 113, 107 S.Ct. 484, 491, 93 L.Ed.2d 427 (1986); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489, 97 S.Ct. 690, 697, 50 L.Ed.2d 701 (1977).[3] As discussed above, the Hospital's Governing Board retained ultimate responsibility for the decision of whether Pudlo's staff appointment would be terminated. Thus, it is inconceivable a conspiracy among individual members of the medical staff was the actual cause of Pudlo's injury. *See Oksanen*, 945 F.2d at 706 ("To speak of a conspiracy among a medical staff during the

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[3] We note that this requirement, akin to that of standing, is distinct from whether a restraint is "unreasonable" under Section 1 of the Sherman Act. As stated in *Atlantic Richfield*, 110 S.Ct. at 1893:

> We also reject respondent's suggestion that no antitrust injury need be shown where a *per se* violation is involved. The *per se* rule is a method of determining whether § 1 of the Sherman Act has been violated, but it does not indicate whether a private plaintiff has suffered antitrust injury and thus whether he may recover . . . under . . . the Clayton Act. *Per se* and rule-of-reason analysis are but two methods of determining whether a restraint is "unreasonable," *i.e.*, whether its anticompetitive effects outweigh its procompetitive effects. . . . The purpose of the antitrust injury requirement is different. It ensures that the harm claimed by the plaintiff corresponds to the rationale for finding a violation of the antitrust laws in the first place.

peer review process is not very meaningful in antitrust terms if the staff lacks the final authority to implement any agreement that it does reach."). Accordingly, even if Pudlo has alleged facts sufficient to establish a conspiracy among the medical staff, no actual injury could flow from the resulting agreement.

In sum, as neither of Pudlo's theories of Section 1 conspiracy is cognizable, we dismiss Counts I and II of his amended-complaint.

III. Section 2 Claims (Count III)

In Count III of his amended complaint, Pudlo asserts that "defendants have been engaged in unlawful combination and conspiracy to monopolize trade and commerce in the provision of general internal medicine services in violation of Section 2 of the Sherman Act." Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in relevant part: "[e]very person who shall . . . combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony. . . . " Pudlo's Section 2 claim, which attempts to allege a "conspiracy to monopolize," merits little discussion. As we have previously concluded that the Hospital is legally incapable of conspiring with its medical staff under Section 1, they similarly lack the capacity to conspire under Section 2. *Oksanen*, 945 F.2d at 710. Respecting Pudlo's claim of a conspiracy among the medical staff itself, to the extent that such a conspiracy existed, no actual injury could conceivably flow from the ensuing

agreement. Accordingly, Pudlo's Section 2 claim must fall.

IV. State-Law Claims (Counts IV & V)

In light of our disposition of Pudlo's federal claims, we pause to evaluate the necessity of exercising supplemental jurisdiction over Pudlo's state-law claims, *i.e.*, tortious interference with a business relationship (Count IV) and breach of contract (Count V). As a general rule, "[w]hen the federal claims are disposed of before trial, the state claims should be dismissed without prejudice almost as a matter of course." *Olive Can Co. v. Martin*, 906 F.2d 1147, 1153 (7th Cir.1990) (citing *Baltimore Orioles, Inc. v. Major League Baseball Players Assoc.*, 805, F.2d 663, 682 (7th Cir.1986), *cert. denied*, 480 U.S. 941, 107 S.Ct. 1593, 94 L.Ed.2d 782 (1987)). Notwithstanding his strained appeal to general notions of judicial economy, convenience and fairness to litigants, Pudlo has failed to present any extraordinary circumstances justifying retention of jurisdiction over these claims, and they are dismissed.

V. Conclusion

In support of his claims under Section 1 & 2 of the Sherman Act, Pudlo relies on two possible conspiracy patterns: (1) that the Hospital conspired with its medical staff; and (2) that the individual members of the medical staff conspired among themselves. Neither of these theories, however, are cognizable under the antitrust laws. First, under the doctrine of intracorporate immunity, a hospital is legally incapable of conspiring with its medical staff during the peer-review process. Second,

although the medical staff is legally capable of conspiring among itself, no actual injury could possibly flow from the resulting agreement. Accordingly, we dismiss Counts I-III of Pudlo's amended-complaint. Further, Counts IV and V are dismissed for lack of supplemental jurisdiction. It is so ordered.

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(To be reported at: 2 F.3d 1153 (Table))
62 USLW 2151
UNPUBLISHED DISPOSITION

Joseph PUDLO, M.D., Plaintiff-Appellant,

v.

E. ADAMSKI, Jr., M.D., J. Schneider, M.D.,
S. Borushek, M.D., et al.,
Defendants-Appellees.
No. 92-1854.
United States Court of Appeals, Seventh Circuit.
Argued Jan. 14, 1993.
Decided Aug. 9, 1993.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division, 91 C 7474; Marvin E. Aspen, Judge.

N.D.Ill.

AFFIRMED.

Before COFFEY, and KANNE, Circuit Judges, and ESCHBACH, Senior Circuit Judge.

ORDER

Joseph Pudlo, M.D. ("Pudlo") is appealing the district court's dismissal of all five counts of his amended complaint. Pudlo purchased a medical practice and obtained provisional medical staff privileges at Resurrection Medical Center (the "Hospital"). The Hospital's Quality Assurance and Risk Management Department, which reviews patient charts to detect deviations from quality standards, forwarded the chart of one of Pudlo's patients to the Hospital's Internal Medicine Committee. As a result, the Internal Medicine Committee began a

review of the care given to that patient. This review ultimately expanded to include six of Pudlo's patients. The Internal Medicine Committee ultimately recommended that Pudlo's provisional staff privileges not be extended, automatically terminating Pudlo's staff privileges at the Hospital. The Internal Medicine Committee's recommendation was forwarded to the Hospital's Executive Committee, made up of 16 doctors, which approved the recommendation. Finally, the recommendation reached the Hospital's Governing Board (the "Board"), which decided to proceed with the termination of Pudlo's staff privileges. Pudlo appealed to the Hospital's Appeals Committee, which recommended that he retain his staff privileges, but the Board, which had final authority, did not relent. After the termination of his staff privileges, Pudlo filed a complaint containing five counts: Counts I and II asserted claims under s 1 of the Sherman Act; Count III asserted a claim under s 2 of the Sherman Act; and Counts IV and V asserted pendent state law claims for tortious interference with contract and breach of contract, respectively.

The defendants moved for dismissal of Pudlo's claims under Fed.R.Civ.P. [PAGE 2] 12(b)(6). The district court dismissed all five counts of the complaint, rejecting the Sherman Act claims on the merits and the state claims for lack of supplemental jurisdiction.[1] Our review of the briefs and the record leads us to conclude that the district

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[1] Our reading of the district court's opinion makes it clear that the court dismissed Pudlo's state claims without prejudice, declining to exercise pendent jurisdiction because all of Pudlo's federal claims had been dismissed.

court carefully considered all issues when granting defendants' 12(b)(6) motion. We affirm for the reasons stated in the district court's thorough opinion, which may be found at 789 F.Supp. 247.

We write separately only to note our agreement with the position taken by the Third and Fourth Circuits that under the doctrine of intracorporate immunity, a hospital is legally incapable of conspiring with its medical staff during the peer-review process, when, as here, the medical staff acts with delegated authority to recommend action to the hospital's board, because the staff is acting in the same way that an officer of a corporation would act in relation to the corporation.[2] For this reason and the

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[2] Oksanen v. Page Memorial Hosp., 945 F.2d 696, 702-05 (4th Cir.1991) (in banc), cert. denied, 112 S.Ct. 973 (1992) (holding that a hospital is incapable of conspiring with its medical staff during the peer-review process when the functional relationship between them is analogous to that of corporation and officer); Nanavati v. Burdette Tomlin Memorial Hosp., 857 F.2d 96, 118 (3d Cir.1988), cert. denied, 489 U.S. 1078 (1989) (holding that "a hospital could not conspire with its medical staff, as an entity, because the staff operated as an officer of the corporation would in relation to the corporation") (emphasis in original) (citation and internal quotation marks omitted).
A Sixth Circuit case, Nurse Midwifery Assoc. v. Hibbett, also provides general support for our position, recognizing that during the peer review process, "members of the medical staff were acting as agents of the hospital . . . therefore, the intracorporate conspiracy doctrine is controlling." 918 F.2d 605, 614 (6th Cir.1990), cert. denied, 112 S.Ct. 406 (1991). However, we note that the support is qualified because the Nurse Midwifery court indicated in dicta that it would not apply intracorporate immunity protection when physicians are making staff privilege recommendations concerning a competitor. Id. In the instant case, the initial recommendation was made by Pudlo's direct compet-

other reasons stated in the district court's opinion, the dismissal of Pudlo's complaint is AFFIRMED.[3]

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itors, but the review by the sixteen-member Executive Committee (twelve of whom were not in direct competition with Pudlo) and the fact that final authority was vested in the Hospital's Governing Board removed any possible resulting taint.
The Eleventh Circuit has taken a contrary position. Bolt v. Halifax Hosp. Medical Center, 891 F.2d 810, 819 (11th Cir.), cert. denied, 110 S.Ct. 1960 (1990) (holding that a hospital and the members of its medical staff are legally capable of conspiring with each other in the peer review context). In addition, the Ninth Circuit expressly adopted the reasoning [PAGE 3] of Bolt in a case outside the peer review context. Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1450 (9th Cir.1988) (citing an identical discussion in Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273, 1280 (11th Cir.1988)). In Oltz, the Ninth Circuit held that anesthesiologists were not acting like officers in relation to a corporation when they pressured the hospital to eliminate a nurse anesthetist as a potential competitor, because their interests were functionally antithetical to the hospital. Id.

[3] On June 22, 1993, Pudlo filed a Motion to File Instanter Citation of Supplemental Authority pursuant to Federal Rule of Appellate Procedure 28(j). On July 2, 1993, the appellees filed an objection to Pudlo's motion. We granted Pudlo's motion and have considered the supplemental authority in rendering this decision.

**UNITED STATES COURT OF APPEALS**

For the Seventh Circuit

Chicago, Illinois 60604

**JUDGMENT – WITH ORAL ARGUMENT**

Date: August 9, 1993

BEFORE: Honorable John L. Coffey,
Circuit Judge

Honorable Michael S. Kanne,
Circuit Judge

Honorable Jesse E. Eschbach,
Senior Circuit Judge

No. 92-1854

JOSEPH PUDLO, M.D.,
Plaintiff - Appellant

v.

E. ADAMSKI, JR., M.D., J. SCHNEIDER, M.D.,
S. BORUSHER, M.D., et al.,
Defendants - Appellees

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division No. 91 C 7474, Marvin E. Aspen, Judge

This cause was heard on the record from the above mentioned District Court, and was argued by counsel.

On consideration whereof, **IT IS ORDERED AND ADJUDGED** by this court that the judgment of the District Court is **AFFIRMED,** with costs, in accordance with the decision of this court entered this date.

(CITE AS: 1992 WL 27002 (N.D.ILL.))

Joseph PUDLO, M.D., Plaintiff,

v.

E. ADAMSKI, M.D., Jr.; J. Schneider, M.D.; J. Daddino, M.D.; Gary Fahrenbach, M.D.; D. Larson, M.D.; B. Levy, M.D.; J. Nabolotny, M.D.; L. Pankau, M.D.; V. Vohra, M.D., Individually T.P. Nassos, M.D.; E.E. Beutel, M.D.; Y. Kim, M.D.; J. Couglin, M.D.; W. Davidson, M.D.; F. Grabiner, M.D.; S. HADAWI, M.D.; F. Mariano, M.D.; D.L. Meyers, M.D.; E.A. Petrus, M.D.; L. Pupillo, M.D., F. Healy, M.D.; A.R. McCall, M.D.; J. Schneider, M.D.; Sister Donna Marie, Chief Executive Officer of the Hospital in their representative capacity and Resurrection Medical Center, in Chicago, Illinois,
Defendant.
No. 91 C 7474.
United States District Court, N.D. Illinois, E.D.
Feb. 12, 1992.

MEMORANDUM OPINION AND ORDER

RONALD A. GUZMAN, United States Magistrate Judge.

Plaintiff Joseph Pudlo has filed an Amended Verified Complaint alleging jurisdiction under Sections 1 and 2 of the Sherman Antitrust Act, 15 U.S.C. sec. 1 et seq. and Section 7 of the Clayton Act, 15 U.S.C. sec. 18. In essence, he alleges that he was denied professional privileges as an M.D. by the defendant, Resurrection Medical Center in Chicago. The case is before this Magistrate Judge on a referral from Judge Aspen to hear and enter a report and recommendation on the plaintiff's motion for preliminary injunction. The parties are now engaged in abbreviated discovery in preparation for the preliminary injunction

hearing. The background facts are as follows. As is the hospital's policy Dr. Pudlo initially enjoyed privileges while on the provisional staff of Resurrection Hospital. After a period of time on the provisional staff the hospital held hearings to determine if he should be removed from the provisional staff to full privileges as a permanent staff member. After a series of hearings, several of which recommended that he not be given permanent staff privileges and one which recommended that he should be given such privileges, the Board of Directors of Resurrection Hospital denied him privileges as a permanent staff member.

Plaintiff now claims that this action was taken not because of any lack of qualifications on his part, but rather to avoid having to compete with him. In December 1991, Pudlo's attorney served a Request to Produce on Resurrection Hospital requesting production of all documents pertaining to the credentials of every member of the Department of Internal Medicine. Such a request, of course, would include notes, documents, and other evidence from the peer review function of all of the members of the Department of Internal Medicine.

The basis for doing so, according to plaintiff, is that these documents might show disparate treatment. That is, that others who were less qualified than he, were granted privilege status while he was not and that this, in turn, could be evidence of an anti-trust conspiracy.

Resurrection Hospital has provided Dr. Pudlo with the complete file of his peer review proceedings, but is refusing to provide the records and files of the peer review proceedings of other physicians. [PAGE 2] Under

Rule 26(b)(1) of the Federal Rules of Civil Procedure, parties may discover any matter not privileged which is relevant to the subject matter in the pending action. Rule 501 of the Federal Rules of Evidence provides that the Federal Common Law of Privilege shall apply in cases based upon a federal cause of action. These two sections therefore mandate that privileged material as defined by the federal common law be protected in federal question cases. See Wm. T. Thompson, Co. v. General Nutrition Corporation, Inc., 671 F.2d 100 (3rd Cir. 1982). Since the complaint alleges a violation of the Sherman Act, 15 U.S.C. Section 1, this is a federal question case. Where, as in the present case, there are both federal and state law questions as well, federal common law of privilege applies. Id. This does not mean however, that the law of the state may not be considered as one of the factors in making the fact intensive determination of whether or not the asserted privilege applies. Memorial Hospital for McHenry County v. Shadur, 660 F.2d 1058, at 1061 (7th Cir. 1981). Where a state provides for a privilege, a strong policy of comity between state and federal sovereignties requires the federal courts to recognize the privilege if this can be done without significant violence to federal substantive and procedure policy. United States v. King, 73 FRD 103, 105 (E.D.N.Y. 1976). To do otherwise would be to subject the citizens of that jurisdiction to a double standard of confidentiality and privacy depending on which court hears a particular case. This result should be avoided if possible. Lora v. Board of Education, 74 FRD 565 (E.D.N.Y. 1977).

Illinois has a law which appears to apply to the present situation. The Illinois Medical Studies Act, Illinois Revised Statutes, Chapter 110, Paragraph 8-201 et seq. (1991) ("Medical Studies Act"). Under this law, documents generated in the course of a hospital's peer review or quality assurance activities are absolutely privileged from discovery in any litigation. The sole exception to this privilege allows a plaintiff seeking the limited judicial review permitted under Illinois Law to access the record of that decision. Id. at P8-2101.

The party asserting the protection of a privilege has the burden of establishing both the existence and applicability of the privilege. Brock v. Gerace, 110 F.R.D. 58 (D.N.J. 1986). Defendant contends that the Illinois Medical Studies Act, Ill. Rev. Stat. ch. 110, provides a privilege that should be applied in this case as a conditional privilege under federal common law. In support of this contention, defendant cites E.E.O.C. v. University of Notre Dame Du Lac, 715 F.2d 331 (7th Cir. 1983). In that case, the 7th Circuit held that a university need not disclose the identity of participants in the peer review tenure process unless the parties seeking the information demonstrated a substantial, particularized need for the information. The court reasoned that confidential peer review is essential to assure that the decisions with respect to who will and will not be given tenure will be made objectively on the basis of qualifications and that there will be a frank and unrestrained discussion and evaluation of a candidate's academic qualifications. The logic being that if the peers conducting the review have to fear that anything they say will be made public and available to the candidate or others, that they will be more

restrained and less likely or less apt to give their true critical evaluation of the candidate.

It is important to note, as the plaintiff points out in his responsive brief, that the court in the E.E.O.C. v. University of Notre Dame Du Lac case, [PAGE 3] while recognizing a certain qualified privilege, did not preclude production of the records requested by the E.E.O.C., rather it merely held that the identity of persons participating in the peer review process could be withheld. This case was one arising in the context of a racial discrimination allegation by a black professor in the department of economics of that university.

The court imposed upon itself a balancing test in the following manner: "Before determining whether to compel disclosure of materials covered by the qualified privilege, the court must apply a balancing test to determine whether the need of the parties seeking disclosure outweighs the adverse effect such disclosure would have on the policies underlying the privilege. . . . A party must conduct thorough and exhaustive discovery to exploit each and every possible source of information prior to seeking those materials protected by the qualified privilege. 'Exploratory' searches will not be condoned. Similarly, the mere fact that a certain information may be relevant or useful does not establish a 'particularized need' . . . The party seeking disclosure . . . must show a 'compelling necessity' for the specific information requested."

After engaging in this balancing test, the 7th Circuit Court of Appeals specifically recognized a qualified academic freedom privilege protecting academic institutions

against the disclosure of the names and identities of persons participating in the peer review process. As pointed out above however, the court did not preclude disclosure of the documents requested, rather only the names and identities of the peers who participated in the review and the court designed a technique for redacting the documents in question to be used in such cases in order to be sure that the materials did not give away the identities of any parties, but at the same time were not redacted beyond what was absolutely necessary to ensure the anonymity of the parties.

The continuing validity of this decision however is doubtful. As the plaintiff points out in his response brief, the United States Supreme Court in the case of University of Pennsylvania v. E.E.O.C., 493 U.S. 182, 110 S.Ct. 577 (1990) denied recognition of the qualified peer review privilege in a case much similar to the Notre Dame Du Lac case. In the University of Pennsylvania case, the Supreme Court stated "Because of what might be thought of as a conflict of circuits in the approach between the 3rd and the 7th Circuit decisions in E.E.O.C. v. University of Notre Dame, supra, and because of the importance of the issue, we granted certiorari limited to the compelled disclosure question." So that it is clear that the issue that the Supreme Court sought to reach was the issue of whether or not there should be compelled disclosure of the peer review process. Part of the Court's reasoning in the University of Pennsylvania case, however, clearly stems from the fact that Congress has specifically eliminated the exemption which educational institutions enjoyed from being sued under Title VII, as it was originally enacted in

1964, thereby evincing a Congressional intent that educational institutions not enjoy any special privilege in Title VII actions. This amendment to Title VII was a considered response to what Congress believed was a wide spread and compelling problem of discrimination in educational institutions. So it is clear that the limited peer review privilege that existed at one time for cases involving alleged discrimination in educational institutions no longer exists. [PAGE 4] Because the University of Pennsylvania holding is based upon specific Congressional action in the area of Title VII discrimination lawsuits, it is not dispositive of the precise issue before this court. The precise issue before us was, in fact, addressed by the 7th Circuit several years before either the Notre Dame Du Lac or University of Pennsylvania cases in Memorial Hospital for McHenry County v. Shadur, 664 F.2d 1058 (1981). In Shadur, the court faced an allegation by a doctor that the defendant physicians, in conspiracy with others, had used the hospital's peer review committee apparatus in order to deny him staff privileges in the hospital not because of his competence, but solely to avoid having to compete with him for patients. On that issue, the plaintiff sought discovery regarding the treatment of other doctors in comparable disciplinary proceedings before the hospital. He specifically sought production of all documents relating to proceedings instituted by the hospital against physicians who had applied for or were granted admission to its medical staff. Proceedings of this kind, the court found, were admittedly privileged under the Illinois Medical Studies Act, Illinois Revised Statutes Chap. 51 Section 101 et seq. 1979, Amended 1981.

In its discussion, the 7th Circuit Court of Appeals delineated several principles to be used in making the determination before them. First, they made it clear, citing United States v. Nixon, 418 U.S. 683, 710, 94 S.Ct. 3090, 3108 (1974), that because evidentiary privileges operate to exclude relevant evidence and thereby block the judicial fact finding function, they are not favored and, where recognized, must be narrowly construed. Second, in deciding whether the privilege asserted should be recognized, the Court held that it is important to take into account the particular factual circumstances of the case in which the issue arises. The Court should "weigh the need for truth against the importance of the relationship or policy sought to be furthered by the privileged, and the likelihood that recognition of the privilege will, in fact, protect that relationship in the factual setting of the case." Ryan v. Commissioner of Internal Revenue, 568 F.2d 531 and 543 (7th Cir. 1977).

In applying this balancing test, the court noted that the need for full disclosure of the relevant documents to the trier of fact was particularly compelling and substantial in this case because the complaint charged a conspiracy by a group of physicians to deny the plaintiff privileges and thereby destroy his practice. Such an action would not only destroy his practice, but would also reduce the availability of medical services to the community at large and tend to strangle the rights of others who might be willing to provide the same services. The Court put it this way "If successful in proving his claim, Dr. Tambone (the plaintiff) would vindicate not only his own right to practice medicine in the Woodstock area but also the strong public interest in open and fair

competition which is embodied in the Sherman Act under which the case arises." Memorial Hospital for McHenry County v. Shadur, supra, at 1062. That such a goal is important to Congress is reflected in the fact that a successful litigant in an anti trust action is allowed to collect treble damages. Such a provision is a strong statement of Congressional intent to foster and promote private antitrust actions. Fortner Enterprises Inc. v. United States Steel Corp., 394 U.S. 495, 502, 89 S.Ct. 1252, 1258, 22 L.Ed.2d 495 (1969). Recently medical costs have increased greatly. Such costs are taking up an ever increasing portion of the Gross [PAGE 5] National Product and causing great concern. Wei v. Bodner, 127 F.R.D. 91 (USDC Dist. of New Jersey, 1989).

The general policy of full disclosure announced in Shadur, supra, and the disfavored status of privileges which tend to frustrate this policy[1] require that the application of any such privilege be limited to those situations where the privilege serves an even greater good than that served by the general principle of the rules of discovery and whatever public interest exists in the particular litigation.

In the application of this balancing test the Shadur Court found that the basic purpose of the state's statutory privilege was to bolster the effectiveness of in hospitable

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[1] Wei v. Bodner, 127 F.R.D. 91 (USDC Dist of New Jersey, 1989) citing Herbert v. Lando, 441 U.S. 153, 99 S.Ct. 1635, 60 L.Ed.2d 115 (1979). They (privileges) " . . . are not lightly created nor expansively construed for they are in derogation of the search for truth." United States v. Nixon, 418 U.S. 683, 710, 94 S.Ct. 3090, 3108, 41 L.Ed.2d 1039 (1974).

peer group review committees and that this was also a very substantial interest. The Court went on to focus on the fact that in a case such as this where it is alleged that the actual peer review apparatus itself is being misapplied what goes on in the peer review committee meetings themselves is absolutely crucial to the proving of the case. It is the disciplinary proceedings themselves that are being called to question. In order to prove his case, the plaintiff must be able to present evidence to other physicians with comparable or worse records than his, were not denied staff privileges. Such evidence, if it exists, would likely be found in the hospital's records of disciplinary proceedings against other doctors and to deny the plaintiff access to this information may very well prevent him from bringing this action altogether. This reasoning flatly contradicts the arguments of the defendant that the information sought by review of these records is at best only slightly relevant and not crucial to the plaintiff's case. Defendants have argued that whatever evidence is found in these peer review proceedings of other physicians would not be of much use to the plaintiff because of the varying standards applicable to the varying types of practices, as well as the different standards which are applicable to staff members who are already permanently on the staff and the admittedly higher standard that is applied to those who seek to join the staff for the first time.

In Shadur, the 7th Circuit has clearly rebutted the argument that the information likely to be found in such peer review records will be of little value to the plaintiff. I find it illogical and indeed rather disturbing that the hospital would admit in a brief by its counsel that it does

not apply the same high standards to doctors already on its staff as it does to doctors who are attempting to enter the staff for the first time. I can find no basis in logic for justifying such a discrepancy. Indeed, if as the defendant has so often alleged in its brief, the hospital's sole purpose in conducting these peer review proceedings is to make absolutely sure that the doctors treating its patients are highly qualified, then it seems to me the same standard should apply both to doctors who are already on staff and to doctors who are seeking to join the staff. The impact on the patients being treated is the same.

This is not to say that the evidence which the petitioner may find in these files will be sufficient in and of itself to prove a case of illegal or unfair competition. I am aware, as was the Court in the Shadur case, that to prove a Sherman Act claim, the plaintiff must also demonstrate that this discriminatory denial of staff privileges that he alleges was in furtherance of the defendant's unlawful conspiracy to restrain trade. However, it cannot be [PAGE 6] denied that the evidence of discriminatory exclusionary treatment which the plaintiff seeks and hopes to find in these files is absolutely essential to his claim. And, as pointed out in the Shadur case, the inability to prove this particular fact has been held fatal in other Sherman Act claims. See Deesen v. P.G.A., 358 F.2d 165 (9th Cir. 1966).

The Shadur Court also pointed out the potential that existed within the framework of peer review groups for doctors to use them for anti competitive purposes. Citing Robinson v. McGovern, 83 FRD 79 (W.D.Pa. 1979) and Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530, (5th Cir. 1978). In doing so, the 7th Circuit hit upon a concern which is shared by Congress. Indeed, in

the passing of the Health Care Quality Improvement Act, 42 USC s 11101-11152, Congress also was very aware of the potential for the abuse of peer review apparatus for anti competitive purposes. In that Act, Congress provided for immunization from liability for statements made and actions taken during peer review processes in the health care field. In that Act, Congress insulated certain medical peer review activities from antitrust liability. The Act essentially immunizes peer review action from liability but only if the action was taken in the reasonable belief that it was in the furtherance of quality health care, 42 USC s 1112, subsection a. Section 1112 of that Act provides certain procedural protections that hospitals and health care institutions must follow in the peer review processes if they wish to take advantage of the limited immunity. The Act also carves out an exception to the immunity from liability for antitrust actions brought by a state attorney general. So it is clear that Congress was extremely concerned about the abuse of such peer review procedures, and carefully drafted its legislation so as to avoid providing protection for such abuses.

The Shadur court concludes its analysis by stating that the public interest in the private enforcement of federal antitrust law is simply too strong to permit the exclusion of relevant and possibly crucial evidence by application of the hospital's privilege. In a footnote in its brief, defendant suggests that the law has evolved since the Shadur decision and that its rationale is no longer persuasive. Again in a footnote in its reply brief defendant argues that in view of the Supreme Court's analysis in the University of Pennsylvania case, the result of the Shadur court is highly questionable due to the Court's

analysis of the plaintiff's need for the information. However, this Magistrate Judge does not so lightly cast aside a 7th Circuit Court of Appeals decision which is so directly on point. And, based upon the analysis above, I believe that the Shadur Court not only addressed the issue of the plaintiff's need for the information, but made a very clear and unambiguous finding that the public interest in private enforcement of federal antitrust law in this context, meaning the context of a decision seeking to review materials of the peer review proceedings of other physicians in an antitrust case, is simply too strong to permit the exclusion of relevant and possibly crucial evidence by application of the hospital's privilege.

Wherefore, defendant's claim for conditional privilege is denied. Defendant Resurrection medical center is ordered to turn over notes, reports, documents, and all other evidence or materials relating to any peer review functions including any such functions by the hospital quality assurance committee; The Internal Medicine Quality Review Committee; The Internal Medicine Department; [PAGE 7] or any other hospital body relating to the qualifications of physicians to provide medical care during the relevant period. The names of any patients which may appear in any such records as well as the address of any such patient shall be redacted from the disclosed documents.

SO ORDERED

Supreme Court, U.S.
FILED
DEC 22 1993
OFFICE OF THE CLERK

No. 93-705

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1993

JOSEPH PUDLO, M.D.,

*Petitioner,*

v.

E. ADAMSKI, M.D.; J. SCHNEIDER, M.D.; S. BORUSHEK, M.D.; J. DADDINO, M.D.; GARY FAHRENBACK, M.D.; D. LARSON, M.D.; B. LEVY, M.D.; J. NABOLOTNY, M.D.; L. PANKAU, M.D.; V. VOHRA, M.D., individually, T.P. NASSOS, M.D.; E.W. BEUTEL, M.D.; Y. KIM, M.D.; J. COUGHLIN, M.D.; W. DAVIDSON, M.D.; F. GRABINER, M.D.; S. HADAWI, M.D.; F. MARIANO, M.D.; D.L. MEYERS, M.D.; E.A. PETRUS, M.D.; L. PUPILLO, M.D.; F. HEALEY, M.D.; A.R. MCCALL, M.D.; J. SCHNEIDER, M.D.; SISTER DONNA MARIE, Chief Executive Officer of the Hospital in their representative capacity; and RESURRECTION MEDICAL CENTER in Chicago, Illinois,

*Respondents.*

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

## RESPONDENTS' BRIEF IN OPPOSITION

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## RESTATEMENT OF QUESTION PRESENTED

I. Whether the courts below properly applied the *Copperweld* doctrine to dismiss Petitioner's Complaint where the Complaint alleged that the Resurrection Medical Center Board retained ultimate authority for the decision to terminate his medical staff membership and clinical privileges but solicited and received recommendations from various medical staff peer review committees pursuant to an express delegation of authority under the medical staff bylaws.

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No. 93-705

IN THE

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OCTOBER TERM, 1993

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**JOSEPH PUDLO, M.D.,**

*Petitioner,*

v.

**E. ADAMSKI, M.D.; J. SCHNEIDER, M.D.; S. BORUSHEK, M.D.; J. DADDINO, M.D.; GARY FAHRENBACK, M.D.; D. LARSON, M.D.; B. LEVY, M.D.; J. NABOLOTNY, M.D.; L. PANKAU, M.D.; V. VOHRA, M.D., individually, T.P. NASSOS, M.D.; E.W. BEUTEL, M.D.; Y. KIM, M.D.; J. COUGHLIN, M.D.; W. DAVIDSON, M.D.; F. GRABINER, M.D.; S. HADAWI, M.D.; F. MARIANO, M.D.; D.L. MEYERS, M.D.; E.A. PETRUS, M.D.; L. PUPILLO, M.D.; F. HEALEY, M.D.; A.R. MCCALL, M.D.; J. SCHNEIDER, M.D.; SISTER DONNA MARIE, Chief Executive Officer of the Hospital in their representative capacity; and RESURRECTION MEDICAL CENTER in Chicago, Illinois,**

*Respondents.*

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**On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

## RESPONDENTS' BRIEF IN OPPOSITION

Respondents respectfully request that this Court deny the petition for writ of certiorari filed by Joseph Pudlo, M.D. on November 4, 1993.

## COUNTER-STATEMENT OF THE CASE[1]

Petitioner is an internist who was a provisional member of the Resurrection Medical Center (the "Hospital") medical staff in 1990-91. He filed this suit after the Hospital's Governing Board voted not to promote him to the Active Staff, thereby terminating his medical staff membership and clinical privileges.

### A. The Peer Review Process.

All appointments to the Hospital's Medical Staff are provisional for a period of 15 months. (Comp. Ex. I at 6.)[2] In accordance with Article III, Section 5(a) of the Bylaws, the clinical competence and other qualifications of all provisional staff members are subject to close scrutiny during this probationary period. (Comp. Ex. I at 6.) Through the Bylaws, the Hospital delegates certain peer review functions to the medical staff. For example, the Bylaws expressly direct each department chairman to observe the performance of each Provisional Staff member holding clinical privileges within his or her department. (Comp. Ex. I at 6.) The chairman must consider reports from the Department of Quality Management/Risk Management ("QM/

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[1] Petitioner's "Statement of the Case" routinely omits citations to the Complaint or any other portion of the record. More importantly, Petitioner's purported rendition of the facts substantially distorts both the Complaint, which Petitioner did not place before the Court, and the decisions below. Under Supreme Court Rule 14.5, Petitioner's failure to present accurately the allegations which the courts below were asked to review is alone "a sufficient reason for denying the petition."

[2] The Amended Complaint, is cited as "Comp." throughout this brief. The Petition for Certiorari is cited as "Pet.". The Appendix to the Petition is cited as "App.".

RM"), which systematically reviews patient charts to detect deviations from quality and utilization standards, as part of the evaluation of Provisional Staff members and overall monitoring of the quality of care rendered in the Department. (Comp. Ex. I at 6, 17, 35-6.)

Upon the expiration of their 15 month tenure, Provisional Staff members are eligible for promotion to the Active Staff. (Comp. Ex. I at 6.) Provisional Staff members who are not promoted to the Active Staff automatically lose their medical staff membership and clinical privileges. (Comp. Ex. I at 6.) While the Hospital's Board considers recommendations from the relevant Department, the Medical Executive Committee ("MEC") and any other committee that reviews the physician, the Board retains the ultimate authority to determine whether a Provisional Staff member should be removed (promoted) to the Active Medical Staff. (Comp. Ex. I at 6.)

**B. The Hospital's Evaluation of Petitioner's Qualifications for Removal.**

In accordance with the foregoing procedure, Petitioner's charts were scrutinized by the Hospital's QM/RM personnel. (Comp. Ex. A.) These personnel uncovered charts evincing deviations from the Hospital's standard criteria. (Comp. Ex. A and C.) The charts were forwarded to Dr. Adamski, who was chairman of the Department of Internal Medicine, the department in which Petitioner held privileges. (Comp. Ex. A and C.) None of the Hospital personnel who selected the charts forwarded to Dr. Adamski are alleged to have been competitors of Petitioner. Nor was their review alleged to have been part of the "conspiracy" purporting to give rise to Petitioner's claim.

On June 17, 1991, and again on July 17, 1991, Dr. Adamski asked Petitioner to explain the deviations from QM/RM standards spotted by the non-physician administrative personnel who reviewed his records. (Comp. Ex. A and B.) Petitioner failed to respond to these requests, despite the fact that, under the Bylaws, he had the burden to establish his qualifications for clinical privileges. (Comp. Ex. B, E and I at 7.)

On July 17, 1991, Dr. Adamski asked Petitioner to explain deviations from Hospital standards reflected in another medical record reviewed by non-physician QM/RM personnel referred through the clinical pertinence screen. (Comp. Ex. C.) Petitioner also failed to respond to this request, even to explain that he was unable to respond because the records were unavailable. (Comp. Ex. E.)

Dr. Adamski then invited Petitioner to attend the August 1991 meeting of the Internal Medicine Committee. (Comp. Ex. E.) In his letter, Dr. Adamski emphasized that it was important that Petitioner explain the instances of apparent substandard medical practices if he wished to be removed to the Active Staff. (Comp. Ex. E.) This informal opportunity to meet with the Department and explain in writing the questionable medical practices under review is not required by the Bylaws. At the meeting, Petitioner was unable to explain the variation from the Hospital's QM/RM standards. (Comp. ¶21.) Consequently, the Department voted unanimously to recommend that Petitioner not be promoted to the Active Staff. (Comp. ¶¶9, 22). The Department is comprised of general internists, as well as specialists who do not compete in the alleged relevant market: general internal medicine services. (Comp. ¶¶7, 19.) As required by the Staff Bylaws, Dr. Adamski transmitted this recommendation to the MEC. (Comp. ¶22, Ex. I at 6.)

The MEC reviewed the departmental recommendation and supporting documentation, as required by Article III, Section 4(d) of the Bylaws. (Comp. ¶¶22, 25, Ex. I at 6.) Based on the documentation reviewed, the MEC also decided to recommend against promotion. (Comp. ¶24.) This recommendation, and the supporting documentation, were forwarded to, and reviewed by, the Board. (Comp. ¶24.) The Complaint does not allege that a single member of the Board competed with Petitioner. Yet, the Board also voted not to promote Petitioner to the Active Staff. (Comp. ¶24, Ex. I at 5-6.)

At his request, Petitioner was provided a hearing in accordance with Article VI, Section 3 of the Bylaws. (Comp. ¶25.) The Appeals Committee Chairman adopted hearing procedures, as required by Article VI, Section 3(b). (Comp. ¶¶27-28, Ex. I at 13.) Petitioner was entitled to present evidence and witnesses, including an expert witness, and was accompanied by his attorney. (Comp. ¶¶27-30.) Dr. Adamski was unaccompanied by counsel and was not as well prepared for the hearing as Petitioner and his attorney. (Comp. ¶29.) Based on the evidence presented, the Committee recommended that Petitioner be promoted to the Active Staff. (Comp. ¶34.)

The Appeals Committee's report and recommendation was forwarded to the MEC. (Comp. ¶33.) Article VI, Section 3(a) of the Bylaws requires the MEC to make its own recommendation following receipt of the Appeals Committee's recommendation. (Comp. at 13.) In other words, the MEC conducts a de novo review of the record and may accept or modify the Appeals Committee's recommendation based upon its review. (Comp. Ex. I at 13.) In this case, the MEC again recommended that Petitioner should not be promoted to the Active Staff. (Comp. ¶33.) This second adverse recommendation was forwarded to

the Board, together with the Appeals Committee's recommendation and all associated reports. (Comp. at Ex. ¶39.)

As mandated by the Staff Bylaws, the Board reviewed the recommendations of both the Appeals Committee and MEC. (Comp. ¶39, Ex. I at 13.) On November 14, 1991, the Board determined that Petitioner failed to satisfy the Hospital's standards for Active Staff membership and thus voted not to promote Petitioner to the Active Staff. (Comp. ¶ 39.) Consequently, Petitioner's medical staff membership and clinical privileges were automatically terminated. (Comp. ¶39.)

**C. The Proceedings Below.**

Petitioner sought damages and injunctive relief under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2. He alleged that the decision not to promote him to the Active Staff was the product of a conspiracy to restrain trade in, and monopolize the market for, general internal medicine services. (Comp. ¶ 7.) He relied on two possible conspiracy theories: 1) that the Hospital conspired with its medical staff or 2) that the individual members of the medical staff conspired among themselves. (App. 6.)

In March of 1992, the District Court issued its Memorandum Opinion and Order dismissing all of Petitioner's claims. The District Court rejected Petitioner's first conspiracy theory, holding that the Hospital was incapable of conspiring with its medical staff under the intra-enterprise conspiracy doctrine articulated by this Court in *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984) (hereinafter the "*Copperweld* doctrine"). The District Court then rejected Petitioner's second conspiracy theory on the grounds that, although medical staff members are capable of conspiring among themselves, the gov-

erning board's retention of ultimate authority for the termination of Petitioner's privileges made it "inconceivable a conspiracy among individual members of the medical staff was the actual cause of Pudlo's injury." App. at 10. The Seventh Circuit unanimously affirmed the District Court's decision in an unpublished order issued on August 9, 1993. App. at 14-17.

## REASONS FOR DENYING WRIT

The petition arises from an unpublished decision by the Seventh Circuit Court of Appeals that has no independent precedential value. The petition does not present any conflict with Supreme Court precedent, it exaggerates the conflict among the circuits and involves no questions of general public importance.

### I.

### THE DECISIONS BELOW REPRESENT A SOUND APPLICATION OF SUPREME COURT PRECEDENT AND DO NOT PRESENT A MAJOR CONFLICT AMONG THE CIRCUITS WARRANTING THIS COURT'S REVIEW.

In order to entice this Court to grant his Petition for Certiorari, Petitioner touts the Seventh Circuit's opinion as expanding the *Copperweld* doctrine "beyond what any other United States Circuit Court of Appeals had done," thereby exacerbating what he labels "a profound conflict among the circuits on this very important issue." Pet. 8-9. Petitioner further bills the decisions below as going "against this Court's precedents on grants of immunities, against Congressional policy on enforcement of antitrust laws in this area of commerce and most importantly an unjust and unfair expansion of a narrow doctrine not suited for this case." *Id.*

In fact, the Seventh Circuit's unpublished, uncitable opinion did none of those things. Rather, it merely affirmed a district court's application of Supreme Court precedent to the facts alleged in the Complaint. In agreeing with the District Court that the Complaint failed to allege an actionable antitrust conspiracy, the Seventh Circuit went no further than the majority of other circuits to have considered similar claims—indeed the opinions below track the language and reasoning of several prior decisions that this Court determined did not warrant *certiorari*. The Seventh Circuit's fidelity to Supreme Court precedent, as interpreted by several other federal circuits, does not merit this Court's review.

### A. The Courts Below Correctly Applied the *Copperweld* Doctrine To Hold That The Hospital Was Legally Incapable of Conspiring With Its Medical Staff Under The Facts Alleged In The Complaint.

The holdings below on the intra-enterprise conspiracy issue are consistent with this Court's opinion in *Copperweld*. First, the District Court correctly articulated the analysis required under *Copperweld* and its progeny:

> Whether the medical staff's relationship to the hospital is sufficiently analogous to an officer's relationship to the corporation involves an inquiry of "substance, rather than form." *Oksanen*, 945 F.2d at 703. Thus, a mere finding that the hospital's medical staff *sometimes* pursues economic interests apart from the hospital is inadequate to conclude that the hospital is *always* capable of conspiring with its medical staff. *See id.* (criticizing the *Bolt* court for ignoring the functional approach mandated by *Copperweld*). Rather, we must examine the substance, rather than form, of the hospital's relationship with its medical staff within the specific context of the peer-review process.

App. 8. *See also Weiss v. York Hosp.*, 745 F.2d 786, 815 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) (*Copperweld* mandates a functional approach to determine whether an alleged intra-enterprise conspiracy is actionable).

The District Court then correctly applied that analysis by thoroughly examining the substantive aspects of the Medical Staff's relationship with the Hospital during peer review as alleged in the Complaint and exhibits thereto. App. 8-9. In particular, the District Court observed the exhibits to the Complaint established that the Hospital's Governing Board *delegated* peer review decision making in the first instance to the medical staff through the Bylaws, and that the actions of the defendant internists alleged in the Complaint were in accordance with these Bylaws. App. 8. The Court further observed that, to the extent individual members of the medical staff opted to pursue interests antithetical to those of the Hospital, the Governing Body retained the ultimate authority to reverse the decision.[3] Based on this analysis, the District Court properly concluded that the medical staff functioned as "an integral and natural extension of the Hospital's management structure, utilizing its expertise in medical care to make an initial determination of whether Petitioner had achieved a certain level of professional competence." App. 8-9.

Not only did the District Court strictly adhere to this Court's mandate in *Copperweld*, its ruling is consistent with the well-reasoned majority rule that has evolved in the context of medical staff peer review at hospitals. *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 702-05 (4th Cir. 1991), *cert. denied*, 112 S. Ct. 973 (1992); *Nurse*

[3] Article III, § 4 of the Medical Staff Bylaws states "the Governing Body is responsible for the final decision based on medical staff recommendations, regarding an individual's reappointment and/or renewal a revision of individual clinical privileges."

*Midwifery Assoc. v. Hibbett*, 918 F.2d 605, 614 (6th Cir. 1990), *modified*, 927 F.2d 904 (6th Cir.), *cert. denied*, 112 S. Ct. 406 (1991); *Nanavati v. Burdette Tomlin Memorial Hosp.*, 857 F.2d 96, 118 (3d Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989); *Weiss v. York Hosp.*, 745 F.2d 786, 814 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985). *See also*, *Purgess v. Sharrock*, 1993-2 Trade Cas. (CCH) ¶70,349 (S.D.N.Y. Nov. 9, 1992) (Chairperson of hospital's anesthesiology department lacked capacity to conspire with hospital to terminate physician's privileges); *Balaklaw v. Lovell*, 822 F. Supp. 892 (N.D.N.Y. 1993) (hospital's board, medical staff and trustees comprised single entity and were incapable of conspiring to violate Sherman Act); *Willman v. Heartland Hosp. East*, 1993-2 Trade Cas. (CCH) ¶70,412 (W.D. Mo. Oct. 19, 1993) (*Copperweld* doctrine applies to hospital peer review); *Okusami v. Psychiatric Inst. of Wash., Inc.*, 959 F.2d 1062 (D.C. Cir. 1993) (under *Copperweld*, complaint failed to allege conspiracy between hospital and physician medical director).

The Seventh Circuit's affirmance of the District Court's analysis likewise did not, as Petitioner contends, go "further than decisions of other circuits."[4] Rather, the Seventh Circuit carefully circumscribed its opinion:

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[4] Petitioners' continued insistence that the *Copperweld* doctrine is a "narrow doctrine not suited for this case" (Pet. 9) ignores the reality that the doctrine has been applied to a variety of economic relationships going far beyond the parent-subsidiary context. *Proctor v. General Conference of Seventh-Day Adventists*, 651 F. Supp. 1505 (N.D. Ill. 1986) (various unincorporated associations and separately incorporated book publishing/selling organizations aligned with the General Conference of Seventh-Day Adventists treated as single entity); *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986) (Blue Cross and Blue Shield appropriately treated as a single entity, even before merger, because they acted as one company for 30 years); *City of Mt. Pleasant v. Assoc. Elec. Co-op., Inc.*, 838 F.2d 268 (8th Cir. 1988) (group of related corporations comprising part of rural electric cooperative did not have requisite plurality to violate Section 1).

> We write separately only to note our agreement with the position taken by the Third and Fourth Circuits that under the doctrine of intra-corporate immunity, a hospital is legally incapable of conspiring with its medical staff during the peer-review process, when, as here, the medical staff acts with delegated authority to recommend action to the hospital's board, because the staff is acting in the same way that an officer of a corporation would act in relation to the corporation.

App. 16. The Seventh Circuit's circumspection also is evident in its declination to publish its opinion. As a result, the Seventh Circuit opinion has no independent precedential value, and cannot be cited as independent authority within or outside the Seventh Circuit. Thus, the opinion in no way exacerbated the nominal split among the circuits on the intra-enterprise conspiracy issue.

Indeed, the very contention that "there is a profound conflict among the Circuits" regarding the applicability of the *Copperweld* doctrine to hospital peer review (Pet. 9) ignores the reality that the Eleventh Circuit is the only circuit in this country to have held that a hospital is capable of conspiring with its medical staff in the context of peer review.[5] *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990). This Court found the *Bolt* decision unworthy of *certiorari*, de-

[5] The Ninth Circuit, which held that a hospital and members of its medical staff were capable of conspiring outside the context of peer review in *Oltz v. St. Peter's Community Hospital*, 861 F.2d 1440 (9th Cir. 1988), has not formally considered the issue of whether a hospital is capable of conspiring with its medical staff *within* the context of peer review. Neither court below endorsed, nor did the Respondents advocate, a rule that would have precluded an antitrust conspiracy in a context outside clearly delegated peer review responsibilities.

spite that decision's creation of a split among the circuits. Since *Bolt* was decided, the Fourth, Sixth and Seventh Circuits, as well as district courts in the Second and Eighth Circuits, have adopted the Third Circuit's holding in *Weiss* on the intra-enterprise conspiracy issue. Thus, *Bolt* remains a singular anomaly.

The majority rule adhered to by the courts below represents a sound application of the *Copperweld* doctrine, which is premised on the principle that "a business enterprise should be free to structure itself in ways that serve efficiency of control, economy of operations and other factors dictated by business judgment without increasing its exposure to antitrust liability." *Copperweld*, 467 U.S. at 773. Delegating investigative and advisory peer review responsibility to a medical staff, while reserving ultimate authority in the governing body, allows hospitals to conduct statutorily mandated peer review activities[6] in the most effective and efficient means possible, namely by soliciting input from those who are in the best position to evaluate a physician's competence: the colleagues who work with him on a daily basis. *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1458 (11th Cir. 1991). This decisionmaking framework can enhance a hospital's reputation for quality and better enable it to compete in the hospital marketplace. *See Weiss*, 745 F.2d at 821 n.60 (effective

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[6] State law and accreditation standards promulgated by the Joint Commission on the Accreditation of Healthcare Organizations mandate that hospitals require their medical staffs to participate in the evaluation of the competence and qualifications of applicants for appointment and reappointment to the medical staff and to forward recommendations to the hospital's governing board, which is to retain final authority over all credentialling decisions. Ill. Hosp. Licensing Act Regulations, 77 Ill. Adm. Code §§ 250.210(a) and 250.310; Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals* (1992) at MS.2.1.

peer review enhances a hospitals' reputation and the quality of care it delivers and is procompetitive). Yet, because a hospital and its medical staff are not competitors, the hospital peer review process does not represent "the sudden joining of independent economic forces that section one is designed to deter and penalize." *Oksanen*, 945 F.2d at 703; *Nanavati*, 857 F.2d at 118. *See Copperweld*, 467 U.S. at 769.

In *Copperweld*, this Court cautioned that adopting a rule that penalizes "coordinated conduct simply because a corporation delegated certain responsibilities to autonomous units might well discourage corporations from creating divisions with their presumed benefits." 467 U.S. at 771. The court in *Oksanen* heeded this warning:

> Penalizing coordinated conduct in the health care context would not only discourage hospitals from investing authority in their medical staffs, but it would also discourage staff members from accepting and exercising delegated authority if to do so involved the omnipresent fear of antitrust treble damages suits.

945 F.2d at 703-04. The opinions below are true to this ideal.

In sum, applying the *Copperweld* doctrine to the facts alleged in Petitioner's Complaint fosters economic efficiency and competition among hospitals without creating the dangers that the antitrust laws were intended to prevent. The lower courts' recognition that the Hospital and its medical staff functioned as a single enterprise in reviewing Petitioner's qualifications for promotion to the Active Staff is sound and does not warrant this Court's review.

**B. The Courts Below Properly Concluded That The Complaint Failed To Allege Antitrust Injury.**

The courts below also properly rejected Petitioner's second conspiracy theory based on the Complaint's failure to allege antitrust injury. Because the Complaint alleged that "the Hospital's governing Board retained ultimate responsibility for the decision of whether Pudlo's staff appointment would be terminated," it was "inconceivable" that a conspiracy among individual medical staff members was the actual cause of Petitioner's injury. App. 10 (citing *Oksanen*, 945 F.2d at 706). Even the Eleventh Circuit, the same circuit that decided *Bolt*, has recognized that, when a non-physician hospital board retains ultimate, unilateral authority for a credentialling decision, the solicitation of input from a physician's competitors through the peer review process does not give rise to an actionable antitrust conspiracy. *Todorov*, 921 F.2d at 1459.[7]

Petitioner mischaracterizes the holdings below when he asserts that the Seventh Circuit's decision "means that as a matter of law . . . members of the medical staff involved in . . . internal peer review [cannot] conspire with

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[7] As the Eleventh Circuit observed, *Todorov* involved facts that were "strikingly similar" to those in *Bolt*. 921 F.2d at 1446 n.13. Nonetheless, the Eleventh Circuit rejected Dr. Todorov's antitrust conspiracy claims, holding that where a hospital board unilaterally rejects a physician's application for privileges, competing physicians who recommend that privileges be denied are not causally responsible for that decision and thus cannot be liable under the antitrust laws.

The defendants in *Bolt* apparently did not argue that the Hospital's action was a unilateral one and that the defendant physicians were powerless to inflict the injury complained of by Dr. Bolt. The *Bolt* opinion contains no discussion of this argument and does not even consider whether the defendant hospitals had a motive for conspiring to deny Dr. Bolt's privileges. 891 F.2d 810.

other members of the medical staff." Pet. 9. Neither the courts below, nor Respondents, quibble with Petitioner's abstract assertion that, in some contexts, the individual members of a medical staff may be driven by competing economic interests and have the capacity to conspire. App. 9. Every corporate agent has independent interests that may be pursued outside the agent's corporate responsibility. *See Mandava v. Howard Country General Hosp.*, 1992-2 Trade Cas. (CCH) ¶69,932 (D. Md. July 1, 1992) (rejecting contention that physician acted as head of medical corporation rather than hospital agent during peer review). When agents act outside their delegated responsibility and/or there is evidence of coercion, perhaps a conspiracy could result. But that hypothetical was not before the courts below.

Rather, the Complaint alleges that Petitioner lost his privileges as a result of a peer review decision by the Hospital Board with input from various peer review committees comprised of physicians. Nowhere does the Complaint allege that the physicians had "captured" the Board or otherwise coerced the Board into denying Petitioner promotion to the Active Staff. Nor does it allege that the Board's decision resulted from physician actions taken outside the scope of delegated peer review duties. Under these circumstances, the courts below properly concluded that "although the medical staff is legally capable of conspiring with itself, no actual injury could possibly flow from the resulting agreement" alleged in the Complaint. App. 13.

This aspect of the District Court's holding, which was affirmed by the Seventh Circuit without discussion, goes

no further than the Fourth Circuit in *Oksanen*[8] and is not inconsistent with the Third Circuit's holding in *Weiss*, wherein the Third Circuit found that physicians exercised "control over York's admission decisions." 745 F.2d at 819. Indeed, as the Eleventh Circuit recognized in *Todorov*, Supreme Court precedent *requires* "a private party seeking to invoke the antitrust laws must show that the defendants caused the alleged injury."[9] 921 F.2d at 1459

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[8] Petitioner struggles to distinguish *Oksanen*, contending that *Oksanen* involved an action initiated by a hospital board while this case involves an action initiated by a competitor. Yet, the Complaint itself contradicts Dr. Pudlo's contention. The Exhibits to the Complaint demonstrate that the Hospital's QM/RM Department initiated the process by submitting charts of patients treated by Dr. Pudlo reflecting deviations from routine QM/RM standards to Dr. Adamski. (Comp. Ex. A and C.) Moreover, as the District Court recognized, the Hospital requires each department chairman to evaluate the Provisional Staff members in his department and recommend whether or not they should be removed to the Active Staff. App. 8. Thus, Dr. Adamski was acting at the behest of the Hospital when he investigated possible substandard care by Dr. Pudlo and when he transmitted his recommendation regarding Dr. Pudlo to the MEC. App. 8.

Petitioner also asserts that *Oksanen* is distinguishable because the peer review procedures followed by the medical staff in *Oksanen* were fair while those followed by the medical staff in this case were not. But neither the Fourth Circuit's opinion in *Oksanen*, nor the opinions in this case, turned on the fairness of the procedures. Rather, the inquiry focused on the medical staff's formulation of recommendations pursuant to a delegation of authority and the hospital board's retention of the ultimate authority for the credentialling decision, including the ability to discount recommendations that were antithetical to the hospitals' interests. Thus, this case is simply not distinguishable from *Oksanen*.

[9] *Todorov* also attests to the propriety of the lower courts' refusal to reach Petitioner's illogical vicarious liability theory. Petitioner argues that, even if the Hospital cannot conspire with its medical staff, it should be vicariously liable for the medical staff's conspir-

(Footnote continued on following page)

(citing *J. Truett Payne Co., Inc. v. Chrysler Motors Corp.*, 451 U.S. 557 (1981), *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104 (1986), and *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977)). This is the hurdle that Petitioner failed to clear in this case.

There is no split among the Circuits as to whether there need be a causal link between an alleged conspiracy and a plaintiff's alleged injury. Petitioner has cited no case to the contrary. Therefore, the non-controversial holdings below on antitrust injury do not warrant this Court's review.

## II.

## THIS CASE IS NOT INCONSISTENT WITH THIS COURT'S DECISION IN *PATRICK* OR CONGRESS' ENACTMENT OF THE HEALTH CARE QUALITY IMPROVEMENT ACT.

Petitioner attempts to pique this Court's interest with a parade of imaginary horribles. First, he maintains that the Seventh Circuit's opinion renders moot this Court's decision in *Patrick v. Burget*, 486 U.S. 94 (1988). Pet. 17. Second, he asserts that the decision contravenes congres-

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[9] *continued*

acy. Again, Petitioner is tripped up by the principle hurdle in this case: the Board—not the internists—terminated his medical staff privileges. Thus, he has not alleged any injury flowing from a conspiracy among the internists. It makes no sense to contend that the Hospital should be vicariously liable for a conspiracy that caused no injury.

It also should be noted that the petition does not offer the vicarious liability theory as an independent basis for review. Thus, under Supreme Court Rule 14, if this Court determines that the lower courts' holdings on intra-enterprise conspiracy does not merit review, Petitioner's vicarious liability theory cannot be an independent basis for *certiorari*.

sional intent as evidenced by the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.* ("HCQIA"). Pet. 19-20. Third, he claims that failure to grant review would exclude the health care industry from ordinary application of Section 1 of the Sherman Act. Pet. 10. All of these claims are plainly unfounded.

Petitioner's contention that the Seventh Circuit's decision somehow moots *Patrick* distorts Supreme Court precedent. *Patrick* involved an entirely different doctrine than is at issue in this case—the state action doctrine—which under the clear precedent of this Court could not be stretched to cover a hospital peer review process that was not actively supervised by the state. Petitioner's novel suggestion that *Patrick* requires a hospital to "actively supervise physician controlled peer review processes," Pet. 17, inappropriately interjects state action principles into the *Copperweld* analysis. The very premise of Petitioner's *Patrick* argument makes little sense—the courts below did not consider whether a *physician-controlled* peer review process would qualify for *Copperweld* immunity because the Complaint alleged a peer review process that was controlled by the Hospital Board. In short, *Patrick* has no bearing on this case and this case has no bearing on the continued viability of *Patrick*.

Nor is HCQIA pertinent to this case. When Congress enacted HCQIA and established an affirmative defense to certain claims arising from certain peer review activities, it expressly provided that HCQIA did not change other "immunities available under law." 42 U.S.C. §11115(a). Thus, Congress did not intend to limit the scope of evolving judicial doctrines, such as the state action doctrine and the *Copperweld* doctrine. *Patrick*, 486 U.S. at 105 n.8.

HCQIA's irrelevance is further demonstrated by the procedural posture of this case. The courts below held that

the Complaint failed to allege an actionable conspiracy. They did not therefore consider whether an affirmative defense, such as HCQIA, might apply. Neither HCQIA nor congressional intent can be twisted to support the petition.[10]

Finally, Petitioner's alarmist rhetoric regarding the anti-competitive abuses that might abound if the lower courts' opinions are allowed to stand must be laid to rest. By no stretch of the imagination does this case extend an immunity that "suffocates competition among physicians." Pet. at 17. This case has no bearing on anticompetitive actions taken by physicians outside the hospital peer review process, or action that is not subject to oversight by a governing body comprised of individuals who do not compete with the complaining physician. In addition, when peer review action is alleged to constitute monopolization or an attempt to monopolize, liability may follow. Thus, the types of abuses highlighted in Sections IV and V of the petition remain subject to antitrust liability under the Seventh Circuit's analysis.

The Seventh Circuit's unpublished, carefully circumscribed opinion will generate none of the iniquities prophesied in

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[10] The GAO Report, *Physician Antitrust Issues—GAO Views*, ¶50,062 Trade Reg. Rpts. 48,714 (1993), cited by Petitioner, is not inconsistent with the Seventh Circuit's Opinion. That Report acknowledged that peer review was largely immune from antitrust scrutiny. The *Copperweld* doctrine is one of the doctrines under which some peer review activities fell outside the scope of the antitrust laws at the time the GAO submitted its Report to Congress. In addition, the Report's observation that "where ultimate power is vested in the Board, rather than competitors of the doctors under review the medical staff may engage in peer without undue exposure" can be read as acknowledging that the medical staff in such cases may qualify for protection under the *Copperweld* doctrine.

the petition and cannot even be cited as precedent in future litigation. Only where a hospital board comprised of non-competitors retains the ultimate authority and responsibility for a peer review decision, soliciting recommendations from physicians pursuant to clearly defined delegations of authority, would the lower court's opinions insulate a hospital and its medical staff from antitrust conspiracy claims. This sound, and almost universally followed, application of the *Copperweld* doctrine and the antitrust injury requirement does not warrant this Court's review.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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December 22, 1993

No. 93-705

DEC 30 1993

In The

# Supreme Court of the United States

October Term, 1993

JOSEPH PUDLO M.D.,

*Petitioner,*

v.

E. ADAMSKI M.D.; J. SCHNEIDER M.D.; S. BORUSHEK M.D.; J. DADDINO M.D.; GARY FAHRENBACH M.D.; D. LARSON M.D.; B. LEVY M.D.; J. NABOLOTNY M.D.; L. PANKAU M.D.; V. VOHRA M.D. Individually; T.P. NASSOS M.D.; E.W. BEUTEL M.D.; Y. KIM M.D.; J. COUGHLIN M.D.; W. DAVIDSON M.D.; F. GRABINER M.D.; S. HADAWI M.D.; F. MARIANO M.D.; D.L. MEYERS M.D.; E.A. PETRUS M.D.; L. PUPILLO M.D.; F. HEALEY M.D.; A.R. MCCALL M.D.; J. SCHNEIDER M.D.; SISTER DONNA MARIA, CEO of the Hospital in their representative capacity and Resurrection Medical Center in Chicago, Illinois,

*Respondents.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit**

## PETITIONER'S REPLY BRIEF

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## REPLY TO THE COUNTER-STATEMENT OF THE CASE

By clear misstatement of allegations of the Complaint[1] combined with argument that the Seventh Circuit correctly decided the case below, respondents avoid the serious issue before the Court, whether the issue presented is important enough to warrant this Court's attention. In effect the Respondents purport to *Answer* the original complaint, a procedure sidestepped below by the filing of a motion to dismiss.

On multiple occasions the Respondents twisted[2] [or supplemented] allegations in the complaint to minimize the anti-competitive acts alleged. For example, the Complaint alleges the Internal Medicine Committee convened to discuss two cases (Comp.¶20) but at that meeting Petitioner for the first time learned of four additional cases which were supposedly examples of substandard care [which Petitioner did not then remember]. These new cases as well as the original cases were little more than "pretext" looking for reasons to terminate Petitioner from the Medical Staff. (Comp.¶¶19, 20, 21)

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[1] The First Amended Verified Complaint is attached to the Reply Brief to appraise the Court that the Petitioner's Statement of the Case was founded on the facts he alleged in the Complaint.

[2] The quote "the Hospital Board retains the ultimate responsibility for the decision of whether Pudlo's staff appointment would be terminated" (Op.Br.p.14), is not contained in the complaint. Instead, this language is the district court's mixed conclusion of law and fact on a motion to dismiss. Petitioner adequately alleged that this was not true. See *infra*.

Respondents pretend Petitioner complains of the Department of Internal Medicine, although the complaint does no such thing. The complaint addresses actions of competitors. (Comp.¶3, 22)

The essence of the Complaint (¶¶23, 26, 29, 31, 32, 33, 34, 36, 37), is that Petitioner's competitors formed a conspiratorial scheme, which was implemented through active help of the Hospital administration by abuse of each and every step in the alleged "peer review".

While Petitioner warned the Board that the process had been usurped by his competitors (Comp.¶38), Respondents *answer* that the Board conducted de novo review. Although Petitioner alleged no such thing, (Comp.¶39) "On November 14, 1991, the Board determined that the Petitioner failed to satisfy the Hospital standards for Active Staff membership and thus voted not to promote Petitioner to Active Staff." (Op.Br.p.5); the complaint went on to allege that the Hospital Board only rubber stamped the competitor's conspiracy (Comp.¶¶37, 39), thereby giving the full force and effect to the antitrust injury.

**Respondents also fail to address allegations of National Practitioners Data Bank Reporting.**

In the context of their answer that pretends a regular process of peer review led in effect to a regular decision not to promote "or tenure" petitioner to the Medical Staff, the reality, (as alleged in the complaint) was that Respondents usurped the peer review process for their own gain in violation of the Anti-trust laws. No "regular process" was involved and Dr. Pudlo was not only "not tenured"

but he was also adjudicated a substandard practitioner by a kangaroo court process which resulted in a hospital report to the National Practitioners Data Bank, (Comp.¶¶37, 39). Such rubber stamping gave full force and effect of the anti-trust injury, all alleged to be caused by Respondents' activity. (Comp.¶¶37, 39)

## IMPORTANCE OF THE LEGAL ISSUES

Respondents attempt to minimize the issue by suggesting the Seventh Circuit correctly decided the case. This obvious non sequitur is followed by others but must not be allowed to obscure the importance of the issue presented. Petitioner does agree the case presents a question concerning "other immunities" preserved by H.C.Q.I.A. (Op.Br.p.18). The question is what are these immunities? The Seventh Circuits opinion extends them beyond all reason and certainly accentuates the existing conflict between the circuits. The Seventh Circuit's decision explicitly recognizes this conflict. What is most important is that this case could not be more timely, for as managed competition becomes the grist for the congressional debate, such uncertainty about the rules of competition in an industry concerning 1/7 of the G.N.P. is simply inexcusable.

If the Seventh Circuit Court is correct, this Court should tell it to the country as a whole. If it is not, that is also of surpassing importance. This Court's petitions are not the proper venue for arguing the merits as Respondents appear to believe.

The bottom line is that the question presented is of surpassing social and economic importance to the country. It deals with no "abstract assertions" by Petitioner that individual members of the medical staff can enter into a conspiracy (Op.Br.p.15) The petitioner alleges just such a conspiracy and abuse of the peer review process, (Comp.¶¶3 & 36), with the Hospital Board's refusal to conduct de novo of actively supervising the process, (Comp.¶¶37, 38).

Petitioner respectfully requests that Certiorari be granted.

DUSAN VUCICEVIC
*Attorney for Petitioner*

**IN THE UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF ILLINOIS,**
**EASTERN DIVISION**

| | | |
|---|---|---|
| JOSEPH PUDLO, M.D., Plaintiff, V. | ) | NO. 91 C 7474 JUDGE ASPEN MAGISTRATE GUZMAN |
| E. ADAMSKI, M.D., JR.; J. SCHNEIDER, M.D.; S. BORUSHEK, M.D.; J. DADDINO, M.D.; GARY FAHRENBACH, M.D.; D. LARSON, M.D. B. LEVY, M.D.; J. NABOLOTNY, M.D.; L. PANKAU, M.D.; V. VOHRA, M.D., individually T.P. NASSOS, M.D.; E.W. BEUTEL MD.; Y. KIM M.D.; J. COUGHLIN M.D.; W. DAVIDSON M.D.; F. GRABINER M.D.; S. HADAWI, M.D.; F. MARIANO M.D.; D.L. MEYERS M.D.; E.A. PETRUS, M.D.; L. PUPILLO, M.D.; F. HEALEY, M.D.; A.R. MCCALL, M.D.; J. SCHNEIDER, M.D.; SISTER DONNA MARIA, Chief Executive Officer of the Hospital in their representative capacity and Resurrection Medical Center in Chicago, Illinois, Defendants. | ) | |

**FIRST AMENDED VERIFIED COMPLAINT**

NOW COMES Joseph Pudlo, M.D. ("Plaintiff") by and through his attorneys. Thomas S. Moore and Dusan

Vucicevic, M.D., J.D., and complains against the Defendants as follows:

## Jurisdiction and Venue

Counts I, II and III arise under the antitrust laws of the United States, more particularly, Section I & II of the Sherman Antitrust Act (15 U.S.C. Section 1, *et seq.*) and Section 7 of the Clayton Act (15 U.S.C., Section 18). This Court has jurisdiction of these actions pursuant to 15 U.S.C., Section 15-22 & 26; 28 USC 1337 as a result of Defendants' violations of Sections I & II of the Sherman Act and Section 3 of the Clayton Act, (15 U.S.C. Section 14). Counts IV and V are a pendent tort and contract action.

## The Parties

1. Plaintiff, Joseph Pudio, M.D., is a board qualified internist and offers to the public general internal medicine services in the northwestern area of the city of Chicago which is defined by the following zip codes: 60631, 60656, 60648, the western parts of the 60646; 60530 and the northern parts of 60634.

2. Defendant, E. Adamski, M.D., is an internist and chairman of the Department of Internal Medicine and member of the Executive Committee at the Resurrection Medical Center. Dr. Adamski has offices and practices general internal medicine two miles from the Plaintiff and is in direct competition in the relevant market.

3. Defendants, J. Schneider, M.D.; S. Borushek, M.D.; J. Daddino, M.D.; Gary Fahrenbach, M.D.; D. Larson, M.D.; B. Levy, M.D.; J. Nabolotny, M.D.; L. Pankau, M.D.; and, V. Vohra, M.D. are internists, Plaintiff's competitors, members of the Internal Medicine Committee, and have offices in the relevant market.

4. Defendants, T.P. Nassos, M.D.; Gregory Fahrenbach, M.D.; E.W. Beutel, M.D.; J. Coughlin, M.D.; J.L. Daddino, M.D.; W. Davidson, M.D.; F. Grabiner, M.D.; S. Hadawi, M.D.; Y. Kim, M.D.; F. Mariano, M.D.; D. L. Meyers, M.D.; E. A. Petrus, M.D.; L. Pupillo, M.D.; F. Healey, M.D.; A.R. McCall, M.D.; and, J. Schneider, M.D. were all at all relevant times, members of the Executive Committee at Resurrection Medical Center.

5. Sister Donna Maria, the Chief Executive officer of the Resurrection Medical Center, at all relevant times in her official capacity attended the Internal medicine, Executive and the Hearing committee meetings. She is also the voting member of the Governing Board of the Medical Center.

6. Defendant Resurrection Medical Center (hereinafter "Hospital") is an Illinois not for profit corporation. It is primary market for provision of hospital services in the northwestern areas of the city of Chicago.

## MARKET

7. The relevant product market is services of general internal medicine. At all relevant times the Plaintiff was in competition with the individual Defendants referred to in paragraphs 2 and 3 above.

8. Plaintiff and the defendants (paragraphs 2 & 3 above) offer services of general internal medicine to the consumers in the relevant market. Doctors sell their services to the consumers who are insured by Medicare, HMO's and private insurance companies. Medicare determines the price of the services and the physicians receive the same payment per unit of service to a patient. HMO's pay physicians a monthly per capita fee for every patient signed up with them. However, HMO's in the market have different per capita fees. HMO's prefer physicians like Plaintiff who are willing to accept patients at lower per capita fees. Private patients choose a physician based on their office hours and fees. Plaintiff charges $40.00 for the initial office visit and $30.00 for the follow up visits. Plaintiff has office hours three times a week from 12:00 p.m. till 8:00 p.m. He also spends more time with a patient than his competitors. He speaks fluent Polish and some non-English speaking patients chose him also for his additional ability to better understand them. Defendant Adamski charges $60.00 for a first time office visit and $35.00 for a follow up. Adamski has office hours ending at 5:00 p.m. Defendants named in paragraph 3 charge for their first and follow up office visits much higher than plaintiff.

9. The relevant geographic market is the northwestern area of the city of Chicago, Cook County, Illinois, which is defined by the following zip code numbers: 60631, 60656, 60648, the western parts of the 60646, 60530 and the northern parts of 60634. The Plaintiff was steadily increasing his share of the market by offering services more sensitive to the patient's needs at lower prices.

**Jurisdictional Interstate Commerce Requirement**

10. The conduct described herein has substantial impact upon interstate commerce. The Defendants' acts and business conduct described below, at all times material herein, affected the interstate commerce by:

a. Medical Center's purchase of medical supplies, products and equipment from the manufacturers and dealers out of state. The interstate flow of funds for payments of the supplies and collection for services sold, was not insignificant and thereby affected interstate commerce.

b. The Medical Center's proximity to O'Hare International Airport makes it a primary medical facility for a large number of patients, from all parts of the United States, who receive medical care at the Defendant's facility. Parties to this action, when on call duty at the Medical Center, compete for this not insignificant number of interstate patients.

c. The Medical Center and all physicians and surgeons parties hereto, contracted with Medicare, HMO's and PPO's located outside the State of Illinois to provide services to their subscribers and receive out of state revenues directly from those and other insurers which constitute a substantial share of their total revenues.

d. Due to the Plaintiff's expulsion from the Medical Center and the resultant blemish on his record, Plaintiff will be unable to practice medicine anywhere in the United States. The reporting of the Defendants' disciplinary action, pursuant to the Federal and State laws, are mandatory to the National Medical Practitioners Data Bank (located outside of Illinois) and the Illinois State Medical Disciplinary Board. Any hospital in the U.S., where the Plaintiff may apply for a

staff membership, is mandated to obtain the information from these report depositories.

e. The conduct complained of herein is an exclusion of a competitor (the plaintiff), under the guise of a challenge to his professional competence. The reports generated subsequent to the Defendants' pretextual disciplinary proceedings will seriously impugn the Plaintiff's professional reputation. Due to the Defendants' actions, a reasonable and the most probable inference is that the Plaintiff will not be able to acquire any further hospital affiliations, therefore he is effectively excluded from competing in any relevant product market in the United States.

f. Medicine is a strictly regulated profession, therefore it is reasonable and most probable to infer that the Plaintiff will not be able to acquire medical licensure in any jurisdiction in the United States. Therefore by the action of the defendants, Plaintiff is precluded from competing in provision of inpatient and outpatient medical services anywhere in the United States.

## BACKGROUND FACTS

11. On or about August 1, 1990, Plaintiff bought a primary care practice from Dr. Leo Stolarski with offices at 5945 North Milwaukee Avenue, Chicago, Illinois. For more than thirty years, Dr. Stolarski has been using Resurrection Hospital as the only hospital facility to admit patients from his practice. In order to provide services of general internist in this practice, Plaintiff has applied and obtained a medical staff membership with privileges in the Department of Internal Medicine at Resurrection Medical Center.

12. In order to keep admissions of all patients from Stolarski-Pudlo practice to Resurrection, the hospital has purchased the tangible assets from Dr. Stolarski. Dr Pudlo was told that a lease-pay back arrangement for these assets was an incentive, which should have resulted in net $6,000.00 payment to him, for his best efforts to promote and enlarge his practice.

13. From August 1, 1990, through November 18, 1991, the Plaintiff practiced general internal medicine without any restrictions. The Plaintiff admitted and successfully treated more than 300 patients from August 1, 1990 through November 18, 1991.

14. A lease-pay back agreement, incidental to Plaintiff's practice purchase, called for Plaintiff's review of the medical records for the Quality Assurance Committee. The hospital never called or offered Plaintiff to perform services agreed upon. Plaintiff was denied the payments in violation of the agreement in the amount $6,000.00.

15. In the middle of June 1991, Defendant Adamski verbally advised Plaintiff, that the Internal Medicine Department reviewed care in a case of his, and that the case is further being considered by the committee. He further stated that unless Plaintiff explains some of the alleged deficiencies his practice at the Hospital may be in jeopardy.

16. A few days later, Plaintiff received a letter from Defendant Adamski dated June 17, 1991, (Exhibit A attached) which request that the Plaintiff explain some aspects of the medical care on the same patient. After he received the letter, Plaintiff went several times to the Medical Records Department of the Hospital and

requested the record in question. The answer at all times was that the chart is not available for his review, since it is being reviewed by the Quality Assurance Committee.

17. On July 17, 1991, the Plaintiff received a registered letter from Defendant Adamski indicating that the Internal Medicine Committee had not received a response to its letter dated June 17, 1991 (Exhibit B.) This letter threatened that failure to respond may jeopardize Plaintiff's staff appointment. Plaintiff also received another letter dated July 17, 1991 (Exhibit C), Adamski's second letter as of the same date, questioning Plaintiff's recording of some aspects of care rendered to another patient.

18. Plaintiff responded in writing to defendant Adamski's second letter of July 17th (referred above), addressing a letter to Defendant Adamski on August 1, 1991 (Exhibit D). This letter was sent prior to the next regularly scheduled meeting of the Department of Internal Medicine. Unable to respond to the first letter dated June 17, 1991 (Exhibit A) the Plaintiff again asked Medical records Department for the record, subject of the aforesaid letter, however he was again denied access to that record.

19. Without waiting for August meeting Defendant Adamski met on July 31, 1991 with a group of internists, which Plaintiff has reason to believe included physicians in competition with Plaintiff. On information and belief Plaintiff states that defendants discussed and agreed upon the ways to exclude Plaintiff from the hospital and means unjustified and pretextual.

20. At the beginning of August, Plaintiff received a certified letter dated July 31, 1991 from Defendant

Adamski, (Exhibit E) asking him to attend the regular August 9, 1991 Internal Medicine Committee meeting for purposes of explaining alleged deficiencies for the two cases committee was to review. Defendant Adamski failed to disclose to Plaintiff prior to the meeting the identity of medical records to be reviewed, whether these records were selected in the process of ongoing quality assurance or were the records reviewed out of the usual quality assurance process. Defendant Adamski failed to disclose alleged deficiencies in any of the records and failed to identify internists who were going to be responsible for the review.

21. The Plaintiff attended the August 9, 1991 meeting where he learned for the first time that besides the two records (See Exhibits A & C) additional four medical records of were presented to the Department. During the meeting, the plaintiff was asked several questions about all six cases. The Plaintiff did not have any opportunity to review five of the records. He was not prepared to discuss the cases especially a case he treated a year prior to the meeting.

22. Defendant Adamski and all of the other Defendant members of the Internal Medicine Committee, upon conclusion of the review, recommended to the Executive Committee termination of the Plaintiff's medical staff appointment.

23. The Executive Committee consists of sixteen members and four of these members are from the Department of Internal Medicine. The other members are representatives of the Hospital based departments, such as Radiology, Emergency Room and Pathology, and other

clinical departments. Generally, physicians on the committee follow the recommendation of the members who practice in the same field of medicine as the reviewed physician. In other words, the other members of the Executive Committee deferred to the decision of the internists.

24. The Executive Committee recommended to the Governing Board to terminate the medical staff membership of the Plaintiff. On September 13, 1991, Resurrection Medical Center by its C.E.O., Sister Donna Marie, directed a letter to the Plaintiff, (Exhibit F) informing him that his medical staff appointment had been terminated by the action of the governing board.

25. The Medical Staff Bylaws provide for the appeal and a hearing before a Hearing Committee to the medical staff members whose appointment is terminated. The Plaintiff requested a hearing (Exhibit G). The Hearing (aka Appeals) Committee was called for October 9, 1991, by its Chairman Dr Edward Gorney. (Exhibit H)

26. At the hearing, Defendant Adamski was present representing the Internal Medicine Committee and the Executive Committee (Exhibit I – Resurrection Medical Staff Bylaws: Article VI, Section 3 b) (IV) (c). There was no mention at the Hearing regarding the criteria required for the prior review of the cases. [Bylaws (Article III, Section 5 9c)]

27. The Plaintiff was accompanied by his attorney. Plaintiff's attorney at the beginning of the Hearing requested that the Chairman of the Hearing Committee establish and articulate the rules of the procedure, which are to govern the Hearing, to assure that all participants

have a reasonable opportunity to present evidence and to maintain decorum. [Bylaws: Article VI, Section 3(b) IV (a)]. Plaintiff's counsel asked that in addition to the Hospital Bylaws, the rules established by the Health Care Quality Improvement Act (HCQIA) also be followed. Sister Donna Marie denied the request stating that the Hearing Committee had already established the rules in the past and therefore would be governed exclusively by the Bylaws and not by HCQIA regulations.

28. Dr. Gorny, the Chairman of the Hearing Committee, ruled that Defendant Adamski shall have an opportunity to speak first and Plaintiff shall be allowed to follow Adamski's testimony. When requested by Plaintiff's attorney to establish a standard of care by which the evidence is to be evaluated, the Chairman Gorny refused to articulate any standard of care. Plaintiff's request that expert witnesses be allowed to testify as to the standard of care was denied.

29. When Defendant Adamski began to testify he failed to explain to the Committee deviations in the care rendered by Plaintiff in the cases that were reviewed. Adamski was completely unable to discuss Plaintiff's alleged deficiencies. He merely read portions of the vague minutes from Internal Medicine Committee. Since Defendant Adamski was unable to provide any specific deficiencies, the members of the Hearing Committee began questioning Plaintiff. The plaintiff's attorney objected and requested a directed verdict in Plaintiff's favor. That request was denied by the Chairman of the Hearing Committee. Thereafter, various members of the Committee threatened Plaintiff's counsel that if he continued to object they would hold against the Plaintiff. Plaintiff's

attorney than requested a permission to cross examine Defendant Adamski, who immediately threatened to leave the hearing if the Plaintiff's attorney was given permission to cross examine him. [Bylaws: Article VI, Section 3(b)(IV)(d)].

30. Plaintiff was then subjected to inquisitorial questioning by the members of the Hearing Committee. Plaintiff's expert witness, Dr. Elliott Kroger (Exhibit J. Affidavit and Curriculum vitae) was permitted to testify in support of Plaintiff's statements. The meeting was then adjourned.

31. At the beginning of the Hearing, Defendant Adamski consulted with the members of the Hearing Committee for fifteen minutes while the Plaintiff, his expert witness and counsel were asked to wait outside the hearing room. Similarly, after the Hearing was adjourned, Defendant Adamski was allowed to remain in the room during deliberations while the Plaintiff, his attorney and expert witness were again, excluded.

32. Medical Staff By-laws require that the Hearing Committee send its report to the Plaintiff by certified mail within twenty days of the Hearing. [Article VI, Sec. 3.(i)] The Defendant Hospital violated its own bylaws and the HCQIA by failing to send the report to the Plaintiff.

33. At its November 6, 1991 meeting, the Executive Committee reviewed the Hearing Committee's report dated October 9, 1991 and ruled that it was incomplete and requested from Chairman Dr. Gorny, (Exhibit K) that

a more detailed report be submitted to the Executive Committee for further consideration. At the same meeting, the Executive Committee recommended termination of Plaintiff's appointment.

34. On November 7, 1991 Plaintiff verbally requested from Defendant Nassos Chairman of the Executive Committee to stay its decision to terminate him, since a detailed Hearing committee report was pending. Some time later Plaintiff learned that both reports state that the Hearing Committee unanimously recommended continuation of Plaintiff's Medical Staff Membership at the Hospital. [First dated October 9, 1991 (Exhibit L) and second dated November 12, 1991. (Exhibit K above)].

35. The final recommendation of these reports referred in paragraph above states "Plaintiff should be removed from the Provisional Status". This decision must be construed according to Resurrection Medical Staff Bylaws Article III, Section 5, (d) "Failure to have Provisional Status removed at the end of Fifteen month period automatically terminates the appointment (Exhibit I above)

36. On information and belief the Executive Committee knew or should have known that defendant Adamski is Plaintiff's direct competitor. It should not have permitted that the decision of the Hearing Committee by impartial physicians be substituted by the scheme of the competitors. Moreover it joined the conspiracy when it willfully failed to follow a good faith procedure in Plaintiff's evaluation.

37. On information and belief the Plaintiff states that Defendant Adamski used his positions and influence

in pressuring the executive Committee and the Hospital to terminate Plaintiff.

38. Plaintiff, by his attorney, drafted on November 11, 1991 a petition and instructed his staff to send it directly to the members of the Governing Board prior to their November 14, 1991 meeting. The access to the names and addresses of the members were denied to him by the Hospital administration. Since Sister Donna Marie, by her agents so requested, communication to the Governing Board went through her office.

39. The Governing Board of the Medical Center ignored the favorable recommendation of the Hearing Committee, failed to remand the recommendation to the Executive Committee and order reconsideration untainted by competitors. Instead the Governing Board proceeded without having full record. Moreover it made its decision without giving an opportunity to Plaintiff to identify and present the errors of the committees below, therefore in fact rubber-stamped the recommendation on the Executive Committee by terminating Plaintiff's medical staff appointment.

## COUNT I

### Sherman Act, Section 1 per se exclusion and boycott

40. Plaintiff realleges and incorporates, by reference, paragraphs 1 through 39 of this Complaint as paragraph 40 of this Count I.

41. The Defendant internists have combined and conspired to eliminate the Plaintiff as their competitor

from Resurrection Medical Center and relevant market. The defendant internists will gain the additional patients by excluding the Plaintiff. Dr. Adamski and Defendant internists have met on various occasions, from June 17, 1991 through November 14, 1991, and discussed the Plaintiff's practice profile and his expulsion from Resurrection Medical Center and relevant market. Defendants resolve and scheme were communicated to the Plaintiff by the Defendant Adamski. The other Defendants have joined in the combination by ratifying group boycott initiated by the internist.

42. Exclusion of the lower priced competitor shall injure the consumers. Private pay and the patients with the standard insurance will be deprived of the more available services at lower prices. The HMO patients are being deprived of the services in the hours when the competitors do not provide any services at all. Medicare patients will be deprived of services by a physician who spends more time with them and thus render better care than his competitors. The consumers preference for Plaintiff has been reflected in higher numbers of private and especially HMO patients which has been steadily increasing from the time he has purchased his practice. Finally HMO delivery contractors will be denied the opportunity to choose lower priced services when selecting general internal medicine providers.

43. The defendants will financially gain by exclusion of their present competitor. Their gains will continue in the future and are to be generally evaluated by the impact of the restraint not just on the Plaintiff, but rather by the impact of the restraint on the other participants

and potential participants in the market from which the Plaintiff has been excluded.

44. If the combination of the conspirators to exclude Plaintiff and other potential participants remains in the relevant market without proper legal remedies, the unfair restraint of trade shall seriously prevent operation of the market.

WHEREFORE, Defendants, unless restrained, will continue with their conspiracy alleged above and thereby prevent Plaintiff from being able to provide general internal medicine services to alternative delivery systems and to medicare patients in the relevant market area. Plaintiff is entitled under Title XV, United States Code, Section 26 to injunctive relief against the loss of business due to Defendants' continuation of the conspiracy in violation of Title XV, United States Code, Section 1.

The Plaintiff also prays for the following: A) Damages in the amount to be determined at trial and trebled. B) For reasonable attorneys' fees. C) For his costs and disbursements herein. D) For such other relief as may be appropriate.

## COUNT II

### Sherman Act, Section 1 per se exclusion and boycott

45. Plaintiff realleges and incorporates, by reference, paragraphs 1 through 39 of this Complaint as paragraph 45 of this Count II.

46. The Defendant internists have combined and conspired to eliminate the Plaintiff as their competitor

from Resurrection Medical Center and relevant market. The defendant internists will gain the additional patients by excluding the Plaintiff. Dr. Adamski and Defendant internists have met on various occasions, from June 17, 1991 through November 14, 1991, and discussed the Plaintiff's practice profile and his expulsion from Resurrection Medical Center and relevant market. Defendants resolve and scheme were communicated to the Plaintiff by the Defendant Adamski. The other Defendants have joined in the combination by ratifying group boycott initiated by the internist.

47. The reporting of the Defendants' disciplinary action, pursuant to the Federal and State laws, are mandatory to the National Medical Practitioners Data Bank (located outside of Illinois) and the Illinois State Medical Disciplinary Board. By operation of relevant federal and state laws, the defendants pretext to the local exclusion and boycott will be elevated to nationwide exclusion. The unfairness of such restraint is to be evaluated not just by the impact on the Plaintiff, but rather by the impact of the restraint on the other participants and potential participants in the markets from which the Plaintiff has been excluded.

48. If the combination of the conspirators to exclude Plaintiff and other potential participants remains in the relevant market, than as a matter of law, without proper and prompt remedies directed by this Court, it will present the unfair restraint of trade anywhere in the United States.

WHEREFORE, Defendants, unless restrained, will continue with their exclusions alleged above and thereby

prevent Plaintiff from providing services in the Hospital's market area. The Plaintiff prays this Honorable Court to expunge his record of any reference to the adverse action and inform the National Medical Practitioner's Data Bank and the Illinois Medical Disciplinary Board that their records are to be expunged of the Defendant's report of an adverse action. In addition to the above, the Plaintiff is entitled under Title 15, U.S.C. Sec. 26 to injunctive relief against the loss of business through Defendants' continuation of the exclusion in violation of 15 U.S.C. Section 1.

## COUNT III

## Conspiracy to Monopolize

49. Plaintiff incorporates by reference and repeats the allegations of paragraphs 1 through 39 inclusive.

50. Beginning from June 1991 and continuing to the present the defendants have been engaged in unlawful combination and conspiracy to monopolize trade and commerce in the provision of general internal medicine services in violation of Section 2 of the Sherman Act, 15 U.S.C. Section 2. Individually named defendant internists and the other physicians yet unknown to the plaintiff have together 80% of the market in general internal medicine, a market share that has been increasing as a result of anti competitive practices.

51. Defendants have, pursuant to the aforesaid combination and conspiracy demonstrated their intent to exclude actual and potential competitors from the relevant market. The defendants have intended to protect their common interests against those of the plaintiff.

51. All of the above actions were undertaken with the intent and purpose to exclude plaintiff from the market for general internal medicine services.

52. As direct and proximate result of the violation of Section 2 of the Sherman Act, alleged herein, plaintiff has been damaged and is continuing to suffer damages. Wherefore plaintiff prays the Court, that defendants conduct herein alleged by adjudged to be in violation of Section 2 of the Sherman Act, prohibiting combination and conspiracies to monopolize.

## COUNT IV

### Intentional Interference with Contract

53. Plaintiff incorporates by reference and repeats the allegations contained in paragraphs 1 through 39.

54. Beginning on August 1, 1991 and continuing to the present the plaintiff has had business relationships with his private paid patients, contracts with alternative care delivery assistance and medicare patients. The defendants knew about these relationships. The defendants intentional actions alleged caused or induced plaintiffs patients or HMO providers to terminate their contracts with plaintiff, constitute unlawful interference with plaintiffs contractual relations and business advantage.

55. Defendants knew or had reason to know that their wrongful interference with plaintiffs contracts such as their termination of Plaintiff's medical staff privileges at the Resurrection Medical Center were unjustified. It will proximately injure plaintiffs trade relations with

third parties as well as its ongoing business. Plaintiff would have continued the business relationship with Resurrection preferred provider group as well as the other HMO's and individual patients, absent conduct of defendants who deliberately interfered with said contracts and prospective contracts for their own gain.

56. As a direct and proximate result plaintiff has been injured in the form of lost profits and injuries to trade relations and good will.

Wherefore, plaintiff prays this Court to award him damages for lost profits and injury to business and goodwill in the amount yet to be determined plus punitive damages.

## COUNT V

### (Action for Breach of Contract)

57. This is an action for judicial review of the adverse action by Defendants against Plaintiff. The Court should assume jurisdiction for the following reasons:

(a) Jurisdiction of the Court is, as set forth above, an action for violation of Federal Antitrust laws; (b) This cause of action is separate and independent of the causes of action set forth in Antitrust Counts, but is between the same parties and based on the same nucleus of the operative facts as set forth in those Counts; and (c) Judicial economy, convenience and fairness to the parties herein will be furthered if the whole case is tried at one time.

58. Plaintiff realleges and incorporates, by reference, paragraphs 1 through 39 of this Complaint as paragraph 58 of this Count V.

59. Resurrection Medical Center Bylaws provide that the first year appointment will be termed provisional and that termination of this appointment can only be for cause. To fairly and completely evaluate professional competence, a systematic review must be established for newly appointed member physicians. The appointee should be informed of the evaluation process and its standards at the time of appointment. Moreover, the Bylaws are specific that the cause is to be determined through a fair hearing process. The Defendant hospital failed to follow its own Bylaws. Furthermore, the Medical Center joined the conspirators by substituting a "no cause" finding of the Hearing Committee with their pretextual scheme of professional inadequacy.

60. The ad-hoc review of the Plaintiff's medical charts conducted by the hospital on behalf of the conspirators was arbitrary and pretextual. The Plaintiff, to the best of his knowledge and belief, knows of no other physician being reviewed as capriciously and egregiously as he was.

61. The Plaintiff was granted a hearing without notice regarding the charges brought against him. The hearing was flawed by the inability of the Committee to establish and follow a fair procedure as requested in the Bylaws. The Plaintiff was prejudiced by the Committee's failure to timely send its favorable report to the Executive Committee and Governing Board of the hospital as well as to the Plaintiff as required by Hospital Bylaws. Although the Committee's report was favorable to the Plaintiff it had no effect on the proceedings at the hospital since its content and transmittal to the relevant committees were deliberately manipulated by the Defendants,

who thereby prevented even this minutia of fairness to ever so slightly impact on the devastating results of the egregious proceedings conducted against the Plaintiff.

WHEREFORE, Plaintiff respectfully prays this Court provide the following remedies:

a. Return Plaintiff to his Medical Staff status quo at the time of the improperly action;

b. Expunge Plaintiff's record of any reference to the adverse action and inform the material Medical Practitioner, Data Bank and the Illinois Medical Disciplinary Board that their records are to be expunged of the Defendant's report of an adverse action; and,

c. Any other remedies considered appropriate by the Court.

Respectfully Submitted,
JOSEPH PUDLO, M.D.,

BY: /s/ Dusan Vucicevic, M.D.
One of His Attorneys

Thomas S. Moore
McCarthy, Duffy, Neidhart & Snakard
180 North LaSalle Street, Suite 1400
Chicago, Illinois 60601
(312) 726-0355

Dusan Vucicevic, M.D., J.D.
2215 York Road, Suite 102
Oak Brook, Illinois 60521
(708) 571-2103

## VERIFICATION

I, Joseph Pudlo M.D., after first being duly sworn under oath, depose and state that I have read the attached Complaint, and am familiar with the facts contained therein and that said facts are true and correct to the best of my knowledge.

/s/ Joseph Pudlo
JOSEPH PUDLO

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 17th DAY
OF December, 1991.

/s/ Lauri M. Goodwin
NOTARY PUBLIC

" OFFICIAL SEAL "
LAURI M. GOODWIN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 10/31/94

Plaintiff's Exhibit A

June 17, 1991

**QUALITY ASSURANCE**
**CONFIDENTIAL**

To: Dr. Pudlo
Internal Medicine

From: Dr. Adamski /s/ EH/MW
Chairman, Internal Medicine

Re: Prugar, Nellie
09-63-42

The medical record in caption was referred to the Internal Medicine Committee from review from the Quality Management/Risk Management screening process. Several issues were raised by the Committee. First, the patient was admitted 2-26-91 with a one-week history of shortness of breath, a productive cough and blood-tinged sputum. Your initial impression was pneumonitis; chest X-ray showed no evidence of active infiltrate or effusion. The WBC was 10.3 with a normal differential; patient was afebrile. Please substantiate your diagnosis of pneumonitis.

Secondly, during this hospitalization, on 3-3-91, the patient experienced a syncopal episode while in the bathroom of her hospital room. The patient was subsequently transferred to a monitored bed, which revealed a bradycardia. In view of this syncopal episode, was further consideration given to a possible cardiac etiology?

Finally, the patient was discharged 3-6-91 and readmitted the same day with recurrent syncopal episode, and subsequently expired. Please address the possibility of a cardiac-related syncopal episode.

Please respond in writing to the Internal Medicine Committee prior to our July meeting. Thank you.

EA:MW:rs

cc: Georgia

Plaintiff's Exhibit B

July 17, 1991

To: Dr. Pudlo
Internal Medicine

From: Dr. Adamski /s/ CJA
Chairman, Internal Medicine

Re: Memo dated June 17, 1991 (attached)
Prugar Nelli
09-63-42

The memo in caption was-sent to you requesting a written response to the Internal Medicine committee prior to the July meeting. To date, no response has been received. This is a reminder. Failure to respond may jeopardize your staff appointment.

EA:MW:rs

Attachment

*VIA REGISTERED MAIL - RETURN RECEIPT REQUESTED*

Plaintiff's Exhibit C

July 17, 1991

To: Dr. Pudlo
Internal Medicine

From: Dr. Adamski /s/ EH/MW
Chairman, Internal Medicine

Re: Todd, Robert
12-44-19

The medical record in caption was referred through the Clinical Pertinence Screen for review by the Internal Medicine Committee. Several deficiencies were identified:

-no review of systems

-physical exam inadequate regarding inventory of body systems, comprehensive physical assessment

-discharge instructions not documented

-no mention of chronic renal failure in the progress notes

In addition, the patient was admitted with a BUN of 115 and Creatinine of 6.6, with no mention of azotemia in the progress notes. In view of these findings, please comment in writing before the August Internal Medicine Committee meeting.

EA:MW:rs

Plaintiff's Exhibit D

JOSEPH Z. PUDLO, M.D.
*Internal Medicine*
5945 N. Milwaukee Ave.
Chicago, IL 60646

Telephone: (312) 631-2442

August 1, 1991

Chairman, Internal Medicine
Edwin Adamski Jr., M. D.
Resurrection Hospital
7447 W Talcott
Chicago, Il 60631

Dear Dr. Adamski,

This letter is regarding your correspondence of 7-17-91, pertaining to Robert Todd. Please review the medical chart because patient had a review of systems covered in the history of present illness, he had just been in the hospital on 3-18-91 and also two previous admissions for 1991. The physical exam covered a general inventory of body systems as recorded on 5-1-91. Chronic Renal Failure (CRF) was documented in the past medical history, in the impression on 5-1-91 and again on a progress note of 5-3-91 thus there was no need to mention azotemia. Discharge Instructions were given to the patient verbally. There is no progress note documenting this, so I do not know if it is missing or misplaced.

Thank you,

/s/ Joseph Z. Pudlo, M. D.
Joseph Z. Pudlo, M. D.

Plaintiff's Exhibit E

Resurrection
Medical Center

7435 West Talcott Avenue Chicago, Illinois 60631-3746
312-774-8000

CERTIFIED MAIL P 718 689 434

July 31, 1991

Joseph Pudlo, M.D.
5945 N. Milwaukee Avenue
Chicago, IL 60631

Dear Dr. Pudlo:

I am writing you concerning two previous letters that were sent to you dated June 17, 1991, and July 17, 1991, respectively. As of now, you have failed to respond to these letters. We ask that you please be present at the next Internal Medicine Committee meeting on Friday, August 9, 1991 at 7:30 AM in the Administrative Conference Room. Your failure to appear may jeopardize your Provisional Status review.

Sincerely,

/s/ E. J. Adamski, Jr., M.D.
E. J. Adamski, Jr., M.D., Chairman
Internal Medicine

EJA:gc

Plaintiff's Exhibit F

Resurrection
Medical Center

7435 West Talcott Avenue Chicago, Illinois 60631-3746
312-774-8000

September 13, 1991

CERTIFIED MAIL NO. P 718 689 436

Joseph Pudlo, M.D.
5945 N. Milwaukee Avenue
Chicago, IL 60646

Dear Dr. Pudlo:

As you know, your Provisional Status review was up for consideration. Acting on the recommendation of the Executive Committee, it was the decision of the Governing Board to not remove you from Provisional Status.

Per the Resurrection Medical Center Medical and Dental Staff Bylaws, this automatically results in the termination of your staff appointment at Resurrection Medical Center. This will become effective within seven (7) days of your receipt of this letter.

Sincerely,

/s/ Sister Donna Marie, C.R.
Sister Donna Marie, C.R.
Executive Vice President/CEO

SDM:gc

cc: Sister Bonaventure, C.R.
T. Nassos, M.D.
E. Adamski, Jr., M.C.
M. Marchi, M.D.

Plaintiff's Exhibit G

JOSEPH Z. PUDLO, M.D.
*Internal Medicine*
5945 N. Milwaukee Ave.
Chicago, IL 60646

Telephone: (312) 631-2442

September 19, 1991

Resurrection Hospital Medical Center
c/o Sister Donna Marie, C.R.
Executive Vice President/CEO
7435 W. Talcott Avenue
Chicago, Illinois 60631

Dear Sister Donna Marie, C.R.,

I have received your letter stating my termination from the Medical Staff at Resurrection Hospital dated September 16, 1991 and I would like to appeal this decision effective immediately. I would like to know if there is a way of stopping or postponing this action by the Hospital.

Sincerely yours,

/s/ Joseph Z. Pudlo, M.D.
Joseph Z. Pudlo, M.D.

Plaintiff's Exhibit H

Resurrection
Medical Center

7435 West Talcott Avenue Chicago, Illinois 60631-3746
312-774-8000

September 26, 1991

CERTIFIED MAIL NO. P 718 689 439

Joseph Pudlo, M.D.
5945 N. Milwaukee Avenue
Chicago, IL 60646

Dear Dr. Pudlo:

A meeting of the Appeals Committee has been called on behalf of your request for a hearing. This meeting is scheduled for Wednesday, October 9, 1991 at 8:30 AM in the Board Room. You are expected to attend this meeting. I would suggest that you refer to Article VI, Section 3, of the Resurrection Medical Center Medical and Dental Staff Bylaws, regarding representation on your behalf. If you have any questions, please feel free to contact me.

Sincerely,

/s/ Edward J. Gorny, M.D.
Edward J. Gorny, M.D., Chairman
Appeals Committee

EJG:gc

Plaintiff's Exhibit K

Resurrection
Medical Center

7435 West Talcott Avenue Chicago, Illinois 60631-3746
312-774-8000

November 12, 1991

TO: Gregory Fahrenbach, M.D., Secretary
Executive Committee

FROM: Edward J. Gorny, M.D., Chairman /s/ E.G.
Appeals Committee

Dear Dr. Fahrenbach:

I received you letter of November 6, 1991 requesting a more detailed report of the actions taken by the members of the Appeals Committee at the October 9, 1991 meeting. No minutes were taken at that meeting.

The established format was that Dr. Edwin Adamski, Chairman of the Internal Medicine Division would present all the cases that were in question. Dr. Pudlo was to answer all the allegations that were felt to be present in each of these cases. This was done on an individual case by case. The members of the Appeals Committee were free to question both parties at any time. When all the members had been satisfied that the matter had been thoroughly presented, the Appeals Committee met in private.

It was clear as to why the cases in question had "fallen out". It was also clear as to the concern of the members of the Internal Medicine Division regarding the management of these cases. Yet, when confronted with the allegations, the answers of Dr. Pudlo seemed appropriate. The

explanations as offered by Dr. Pudlo were not refuted or questioned further by Dr. Adamski, leading the members of the Appeals Committee to believe that Dr. Adamski was reasonably satisfied with the answers that were given. Individual members of the Appeals Committee also questioned Dr. Pudlo, and were reasonably satisfied with his answers and explanations.

Therefore, after weighing the evidence as presented by Dr. Adamski and after hearing the answers as given by Dr. Pudlo, it was the conclusion of the members of the committee that the charges were not of sufficient magnitude to warrant prohibiting Dr. Pudlo's removal from Provisional Status. It was a unanimous vote (1 abstain) that Dr. Pudlo should be removed from Provisional Status.

EJG:gc

cc: T. Nassos, M.D., Chairman, Executive Committee
Sister Donna Marie, C.R.
Sister Bonaventure, C.R.
Joseph Pudlo, M.D.

Plaintiff's Exhibit L

Resurrection
Medical Center

7435 West Talcott Avenue Chicago, Illinois 60631-3746
312-774-8000

October 9, 1991

TO: T. Nassos, M.D., Chairman
Executive Committee

FROM: E.J. Gorny, M.D., Chairman
Appeals Committee

Dear Dr. Nassos:

The Appeals Committee met on October 9, 1991, to hear the appeal of Dr. Joseph Pudlo regarding his removal from Provisional Status. After careful consideration of the evidence presented, it was the opinion of the members of the Appeals Committee that, based on the evidence presented, Dr. Pudlo should be removed from Provisional Status.

/s/ E.G.
EJG:gc